BlueCross BlueShield of Montana

Authorized Representative for Internal Appeal and External Review

This form must be completed prior to returning to Blue Cross and Blue Shield of Montana.
Patient Name:
Group Number:
Subscriber Number:
Patient Phone Number:
Provider Name:
Claim Number(s) or Service Description:
Dates of Service:
Person / Entity authorized to act on your behalf:

Please note:

- If you are the patient and are 18 years of age or older, your signature is required.
- If the patient is a minor and you are the patient's Parent, Guardian or Authorized Representative, please sign your name below with the date and include your relationship to the patient.

If this authorization is signed by someone other than the patient and the patient is 18 years of age or older, THIS AUTHORIZATION WILL NOT BE ACCEPTED unless a separate authorization signed by the patient is on file to release the patient's Protected Health Information. If you have any questions please contact the customer service number located on the back of the member ID card.

I authorize the person noted above to file an appeal or external review, as applicable, on my behalf. I am aware that I or my authorized representative may submit additional information to be included with the appeal or external review.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient