



BlueAdvantage Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

AUTHORIZED REPRESENTATIVE APPOINTMENT FORM

I, _____ hereby authorize _____,
(member name) (name)

whose address is _____
street city state zip code

and telephone number is () _____, to communicate with BlueAdvantage

Administrators of Arkansas on my behalf regarding the _____
(service, supply, prescription drug, equipment or treatment)

performed or to be performed on _____, 20__ by _____
(physician or health care provider)

I understand and agree that my Authorized Representative shall have the authority to represent me in all matters concerning my health claim.

I understand and agree that BlueAdvantage Administrators of Arkansas shall send correspondence, notices and benefit determinations in connection with my health claims to the Authorized Representative, upon their request for such information. I further understand and agree that it will take BlueAdvantage a reasonable period, approximately thirty (30) days, to notify all its personnel about the termination of this appointment of the Authorized Representative and it is possible that the Company may communicate information about me to the Authorized Representative during this notification period.

This authorization shall remain valid until I notify BlueAdvantage in writing to terminate it or until this health claim has been resolved, whichever occurs first.

Member Signature

Date Signed

Member Name (Print)

BlueAdvantage ID Number