



BlueAdvantage Administrators of Arkansas

An Independent Licensee of the Blue Cross and Blue Shield Association

AUTHORIZED REPRESENTATIVE APPOINTMENT FORM

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

address is _____ and telephone
street city state zip code

number is (____) _____, to communicate with BlueAdvantage Administrators of Arkansas on
my behalf regarding the _____ performed or to
(service, supply, prescription drug, equipment or treatment)

be performed on _____, 200__ 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 all correspondence, notices and benefit determinations in connection with my health claim to the Authorized Representative. 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 (Printed)

BlueAdvantage I.D.#