One Sports Rx 2441 W. Horizon Ridge Parkway Henderson, NV. 89052 714-378-1100 Fax 714-378-1150

For Appeal to My Insurance/Health Plan to Pay for My Medical Claims Designation of Authorized Representative

RE:	Patient Name:	Plan No.:		
	Insured Name: Same	Insured ID:		
	Employer for Insured:			

In the event that my claim(s) in a significant amount for medically appropriate health care is/are improperly denied or underpaid by my insurance/health plan, which may result in financial hardship, disturbance or medical indigence in paying for such significant amount of medical expenses at this time, I hereby designate my healthcare provider listed above to take all necessary steps, as my authorized representative on my behalf, to pursue administrative or judicial appeals, in order to seek reimbursement payments for my medical expenses that I am otherwise legally entitled to under the terms of my insurance/health plan as well as pursuit of any fiduciary breach in administration of the plan. I would like to make this designation and authorization absolutely clear and to the fullest extent permissible under applicable federal and state laws, for my authorized representative to pursue and appeal a benefit determination under my insurance/health plan, to act and to directly receive reimbursement payment checks, notices and any applicable judicial remedies, on my behalf with respect to my significant balance for this medical claim. In the absence of a contrary direction from myself, my insurance/health plan must comply with applicable federal and state laws by directing all information and notifications, to which I am otherwise legally entitled to under the terms of my insurance/health plan and applicable federal and state laws, to my authorized representative, as listed above, authorized to act on my behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, SPD and remedies, reimbursement checks, etc.).

Both federal and state laws protect my rights to appeal for improper denials for my medically appropriate health care, especially in this case with such a significant balance in my account. The applicable federal laws specifically prohibit anyone from precluding or interfering with my rights to designate, to assign my healthcare provider as my authorized representative to exercise such protected right in helping me in this regard of medical and financial security because my healthcare provider has better knowledge and skills in medical science, clinical experience, billing and coding terminology in healthcare delivery industry.

Time is of the essence, and the applicable federal laws require prompt verification procedure completed and response to my appeal in 30 days and no more than 45 days if you need additional information. If you have any questions regarding this authorization, please act so within timeline as mandate by federal laws. Failure to adjudicate my claims and my appeals as required by federal law may impose more financial hardship on me and negatively affect my credit profile, more dangerously; refusal to pay my account properly will discourage me or prevent me from seeking prompt medically necessary care for my current and future medical conditions.

This assign	nment will remain in e	ffect until revoked by	me in writing.	A photocopy of	of this a	assignment is
to be considered a	s valid as the original.	I have read and fully	understand this	agreement.		

Date

Signature of Patient / Guardian