WRITTEN CONSENT TO APPEAL FORM

In accordance with the State and Federal appeal regulations for Medi-Cal, **appeals filed by a provider on behalf of a member, <u>must be accompanied by written consent from the member</u>**. Please complete this form and return to CenCal Health.

Member Name	
Member ID#	
Member's Date of Birth	
Provider Requesting Appeal	
Denied Authorization Number/ Description of Appeal	
Date of Notice of Action (Letter)	

I, ______________________________, give my consent to allow CenCal Health to process the appeal submitted by my provider, ______________________________. Please discuss any aspects concerning this appeal with my provider, which may include disclosing confidential medical information, as needed.

Signature: ___________________________________ **Date:**_____________________

(Member / Authorized Representative)

Please fax this form to CenCal Health at: 805-692-1684 **or**

Mail form to:
CenCal Health
Attention: Grievance & Appeals
4050 Calle Real
Santa Barbara, CA 93110