Harris Plastic Surgery
500 Montauk Highway
Suite H
West Islip, NY 11795
Tax ID# 38-3671960

MEMBER AUTHORIZATION FORM FOR A DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

Date: _____

Patient Name: _____

Insurance Company Name: _____
Member ID #: _____

I, _____, hereby authorize Dr. Stephen Harris, Harris Plastic Surgery and his billing office, to appeal on my behalf the insurance company's determination concerning my surgery on _____. As my designated representative, and as part of the appeal, I hereby authorize my insurance company to communicate with my designated representative concerning the following: all medical and financial information contained in my insurance file. I understand this information is privileged and confidential and will only be released as specified in this authorization.

_____ _____

Patient Signature **Date**