Associated Benefit Consultants

This authorization is voluntary and you may refuse to sign this authorization.
The information you authorize us to disclose may be re-disclosed by the recipient, as the information may no longer be protected under the Federal Privacy Rule.

I hereby authorize Associated Benefit Consultants to use or disclose the specific information as described below:

Description of the specific information to be used or disclosed:

_____

_____

_____

Recipient of the information: Associated Benefit Consultants
This information may be used / disclosed for only the following purpose(s):

_____

_____

_____

This authorization shall remain in effect from the date signed below until (please check one):

____ Expiration event: Date of Contract Termination

____ Specific date: _____

____ One year from the date this authorization is signed

Member Name:_____Date:_____

Member Number:_____Date:_____

Member Signature:_____Date:_____

Signature of member's legally authorized representative (signers other than the member must present legal documentation that authorizes them on the member's behalf)

_____ _____
Printed Name of Member's Representative Relationship to Member

You have the right to revoke any written authorization, except to the extent that we have taken action in reliance on the authorization, by writing to us at Associated Benefit Consultants, 604 S. Jones Las Vegas, NV 89107 - Attention: Client Relations

Associated Benefit Consultants may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits on completion of this authorization.

COVERED INDIVIDUAL'S WRITTEN DESCRIPTION OF DECISION IN DISPUTE

Please describe in your own words the disagreement with the denied service/claim(s).

Indicate clearly the service(s) that is being denied and the specific date(s) being denied. Explain why you disagree and attach any additional pages if necessary.

Include available and pertinent medical records, any information you received concerning the denial, any pertinent peer literature or clinical studies and any additional information from your physician/health care provider that you want included in the reconsideration of the denied service/claim(s).