

# APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION TO APPEAL FORM

I, \_\_\_\_\_ appoint \_\_\_\_\_

\_\_\_\_\_ (Provider of care) at \_\_\_\_\_

\_\_\_\_\_ (Provider's address) as my

Representative to appeal any claims on my behalf.

I understand that if I decline to sign this form, I am responsible for all charges.

\_\_\_\_\_  
Signature of the Beneficiary

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Sponsor SSN

This form should be mailed to: Tricare South Region  
Appeals Department  
P.O. Box 202002  
Florence, S.C. 29502-2002

Or, faxed to: Attn: Priority II Department / 843-317-1532