

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