MEMBER AUTHORIZATION FOR A DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

Date: _____

Insurance Company: _____

Member Name: _____

Member ID: _____

I hereby authorize Triton Medical Solutions to represent me as my Designated Representative in all aspects of processing my appeal.

I understand that the information may be privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

X _____ _____

Signature of Member or Legal Guardian — Date

Representative: _____

Title: Billing Coordinator

X _____ _____

Signature of Designated Representative — Date