AUTHORIZED REPRESENTATIVE FORM

This form is required to file health claim appeals on your behalf.

Provider Name: Sonterra Dermatology, PLLC

Provider Address: 1314 E Sonterra Blvd. Suite 2201, San Antonio, TX 78258

Description of services that may be appealed: Professional Dermatology Services

Date of services were provided: _____ (and any future dates of services unless rescinded)

Patient Name: _____

Patient Address: _____

I agree to allow this health care provider to file an appeal on my behalf with the following health plan if there is a question about coverage for the services listed above. I understand that that if I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time. This consent shall be automatically rescinded if my health care provider does not file an appeal or stops appealing my case.

_____ (Initials) I acknowledge I have read the above statement and understand the information in its entirety. In lieu of reading the above agreement, it has been read to me and explained to my satisfaction.

_____ _____

Signature (Guarantor) Date

Name of Health Insurance: _____

Patient Subscriber ID:_____