Appointment of representative for appeal

This form allows a Quartz member to pick someone to act on their behalf in pursuing an appeal. Please complete the form and return it by:

Mail: Attn: Appeals Specialists, Quartz, 2650 Novation Pkwy, Fitchburg, WI 53713
Email: AppealsSpecialists@QuartzBenefits.com
Fax: (608) 644-3500

Member information		
Member name:	Member ID number:	
Medicare number (beneficiary as party) or National Provider Identifier (provider or supplier as party):		
Member address:		
City:	State:	ZIP code:
Member phone number (with area code):	Email:	
Provider name:	Name of service:	
Location of service:		Date of service:

I, _____ (member) hereby appoint _____ (authorized representative) to act on my behalf in connection with the appeal of the above noted service. I authorize my representative to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance, or request wholly on my behalf. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of party seeking representation: _____ Date: _____

Authorized representative information		
Name of authorized representative:		
Professional status or relationship to the party, (e.g. attorney, relative, etc.):		
Address of authorized representative:		
City:	State:	ZIP code:
Phone number (with area code):	Email:	

I, _____ hereby accept the above appointment.

Signature of representative: _____ Date: _____