Floyd Health System
AUTHORIZATION FOR APPEALING DENIALS

PATIENT'S NAME: _____

(Or Place Patient Identification Sticker here)

PATIENT'S SOCIAL SECURITY NUMBER: _____

DATE OF ADMISSION: _____

I, the above-named patient, hereby authorize any facility of the Floyd Health system to act as my authorized agent/Representative and to act on my behalf as necessary to appeal any denial of payment or underpayment by any insurance company/ health plan for medical services provided to me by the facility in the Floyd Health system, (which includes Floyd Healthcare Management, Inc. and any affiliate or subsidiary thereof, including Floyd Medical Center, Polk Medical Center, Floyd Cherokee Medical Center, Floyd Behavioral Health, Floyd Primary/Urgent Care, Floyd Heyman Hospice Care and Floyd Rehabilitation Services.)

I acknowledge and understand that Floyd Health system facility is not obligated to appeal or dispute any such denial or underpayment and that the facility reserves the right to bill me for services for which payment is denied, disputed, or underpaid by my insurance company or health plan.

_____ _____

Signature of Person giving consent Date and Time

_____

Relationship to patient, if not patient

_____

Patient unable to sign reason

_____ _____

Witness signature Date and Time

Patient Identification