



**A Turn For The Better**

Formerly MCA Administrators

### **Appointment of Authorized Representative**

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize \_\_\_\_\_ to pursue my appeal on my behalf.

\_\_\_\_\_  
Signature of Covered Person (or Legal representation)\*  
\*(Parent, Guardian, Conservator or Other – Please Specify)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Address of Authorized Representative: \_\_\_\_\_  
\_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Please fax to: 412-202-5763 or email to [www.mcoa.com](http://www.mcoa.com)