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| --- |
| *Date* |

|  |  |
| --- | --- |
| Patient Name: |  |
| Reference #: |  |

**CONSENT TO RECEIVE UTILIZATION MANAGEMENT DETERMINATION NOTICE(S) VIA FACSIMILE**

Type of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Service (start of care): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my consent to Healthcare Management to provide written notices relating to Utilization Management determinations for the specific healthcare service for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Full name of patient).

I understand that by signing this Consent I agree to receive such written notices at the facsimile number provided below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secure Facsimile Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Patient (or their authorized representative\*) or the Authorized Representative of the {{providerName}}

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of the Patient (or their authorized representative\*) or the Authorized Representative of the {{providerName}}

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If requestor is other than the patient, please provide as applicable (relationship or provider name)

**\*If the patient is under 18 years of age, a Parent or Guardian must sign. If signature is that of an authorized representative of the patient, a valid power of attorney or personal representative form must be on file with the insurance company.\***

**\*\*Notice: This authorization is effective only for the type of service and date of service listed and expires within 180 days from either the signature date of the patient (or their authorized representative) or the provider’s representative.\*\***