



APPEAL AUTHORIZATION

This Authorization allows **ClearPath Appeals** to act on behalf of the Provider listed below for the sole purpose of preparing, submitting, and following up on healthcare claim appeals with insurance payers.

SECTION 1: PROVIDER / PRACTICE INFORMATION

Practice / Facility Name:

Provider NPI:

Tax ID (TIN):

Practice Address:

Primary Contact Name & Title:

Phone Number:

Secure Fax Number:

Secure Email Address:

SECTION 2: AUTHORIZATION & SCOPE OF REPRESENTATION

The undersigned Provider hereby authorizes **ClearPath Appeals** to:

- Act as the Provider's **authorized representative** for healthcare claim appeal purposes
- Review denied claims and related documentation
- Prepare written appeal letters and supporting narratives
- Submit appeals and supporting documentation to payers
- Communicate with insurance carriers regarding appeal status

Provider Representative: _____

Signature: _____

Date: _____