6022 S. Lindbergh Blvd., Ste.100
St. Louis, MO 63123
314-845-7751
fax: 314-845-7752

pskids@pskidstherapy.com
www.pskidstherapy.com

AUTHORIZED REPRESENTATIVE DESIGNATION

Member Name:_____ **Member DOB:** _____

Member ID: _____ **Today's Date:** _____

You may have PS Kids act on your behalf in an appeal. The person you list below will be accepted as your representative. Your insurance company may not speak with anyone from PS Kids regarding your appeal without this form.

I, _____want the following person to act for me in my
(Printed name of Member's Parent or Legal Guardian)

appeal. I understand that personal medical information *(including secondary release of information—reports or medical documents from other facilities)* related to my appeal may be disclosed to representative:

1. Name of Representative (Please Print): _____,P.S. Kids, LLC_____
2. Contact info for Representative: 6022 South Lindbergh Blvd.
   Ste. 100
   St. Louis, Mo 63123

   Phone: 314-845-7751 **Fax:** 314-845-7752 **Cell:** _____
3. Brief description of the appeal for which the Representative will be acting on my behalf:

   _____

   _____

   _____
4. Parent or Legal Guardian Signature: _____

   Relationship to Member: ☐ Self ☐Parent ☐Legal Guardian
5. Representative Signature: _____
6. Relationship to Member: ☐Director of Therapies, P.S. Kids ☐Billing Coordinator, P.S. Kids

   ☐Other: _____