Authorized representative cancellation form

I, _____ hereby cancel the authorization previously granted to
(member name)

_____, whose address is _____
(name) (address)

_____ _____ _____ and telephone number is
(city) (state) (zip)

_____, to communicate with BlueAdvantage Administrators of Arkansas on my behalf regarding
(phone)

the _____ performed or to be
(service, supply, prescription drug, equipment or treatment)

performed on _____ by _____.
(date in mm/dd/yyyy format) (physician or healthcare provider)

This cancellation revokes the previous request to send all correspondence, notices and benefit determinations in connection with my health claim to the Authorized Representative. I understand and agree that it will take BlueAdvantage Administrators of Arkansas a reasonable period, approximately thirty

(30) days, to notify all its personnel about the termination of this appointment of the Authorized Representative and it is possible that the Company may communicate information about me to the Authorized Representative during this notification period.

Member signature	**Date signed**
Member name (Printed)	**Member ID**

The request must be mailed or faxed to:
BlueAdvantage Administrators of Arkansas
Attn: Customer Service
PO Box 1460
Little Rock, AR 72203

or

Fax: 501-301-1989