



## APPEALS AUTHORIZATION

I, \_\_\_\_\_ (patient/guardian), grant AxioBionics, LLC authorization from this day forward to represent me in the appeals process with my insurance company or any third-party entity for any denial received for AxioBionics products and services.

_____	_____	_____
Authorized Representative (print)	Signature	Date
_____	_____	_____
Patient Name (print)	Signature	Date
_____		
Street Address		
_____	_____	_____
City	State	Zip Code
Country: <input type="checkbox"/> United States	_____	
	Country	
_____	_____	
Email	Phone	