Tactile
MEDICAL™

APPOINTMENT OF REPRESENTATIVE

MEMBER/PATIENT NAME	POLICY ID

I authorize Tactile Medical at 1331 Tyler Street NE, Suite 200, Minneapolis, MN 55413, to act as my representative in connection with any formal/informal grievance or appeal for the Pneumatic Compression Device [PCD] as prescribed for (member/patient)________________________________.

I authorize Tactile Medical to make or give any request or notice, to present or elicit evidence, obtain medical information, file appeal papers, and/or make telephone calls on my behalf.

I direct all parties to this appeal, including (health plan)________________________________, to copy all correspondence and other writing pertaining to this appeal, and to provide any notice in connection with this case to Tactile Medical at the following address:

Tactile Medical
1331 Tyler Street NE, Suite 200
Minneapolis, MN 55413

SIGNATURE	ADDRESS
TELEPHONE NUMBER	**DATE**

Tactile Medical
1331 Tyler Street NE, Suite 200
Minneapolis, MN 55413 USA

Toll-Free Tel: 866.435.3948
Toll-Free Fax: 866.435.3949

Hours: Monday through Friday, 7 a.m. – 7 p.m. CT
www.tactilemedical.com

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