Crescent City Surgical Centre
3017 Galleria Drive
Metairie, LA 70001

Date_____

Blue Cross Blue Shield of Louisiana
PO BOX 98045
Baton Rouge, LA 70898

Contract # _____

I, _____ hereby **authorize** Crescent City Surgical Centre to file a **1st and 2nd Level appeal on my behalf** for services rendered to me on _____.

Please provide Crescent City Surgical Centre with **any and all** correspondence in relation to the appeals.

_____ _____
Patient Signature Date