



AUTHORIZED REPRESENTATIVE DESIGNATION

You may have someone else act on your behalf in an appeal or grievance/complaint. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form. Return to us at:

Ambetter Health of Delaware
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

If you have any questions, please call us at: 1-833-919-3214 (TTY 711)

I, _____ (Printed Name of Member) want the following person to act for me in my Appeal or Grievance/Complaint. I understand that personal medical information related to my Appeal or Grievance/Complaint may be disclosed to my representative.

1. Name of Representative (Please Print):

2. Address of Representative:

Street Address or PO Box	Apt #
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City	State	Zip Code
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Phone Number: Daytime	Phone Number: Evening

3. Brief description of the appeal or grievance/complaint for which the Representative will be acting on your behalf (Include the denied Authorization Number, if applicable.):

4. Member Signature:

Signature of Member (or Parent/Guardian)*

Member DOB: _____

Member ID: _____

Date: _____

* Relationship to Member: Self Parent Guardian

5. Representative Signature:

Signature of Member Representative*

Date: _____

* Relationship to Member: Parent Guardian Other – Please Specify
