



## 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  
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: 1-833-543-3145 (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):

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### 2. Address of Representative:

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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.):**

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**4. Member Signature:**

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Signature of Member (or Parent/Guardian)\*

Member DOB: \_\_\_\_\_

Member ID: \_\_\_\_\_

Date: \_\_\_\_\_

\* Relationship to Member: ☐ Self ☐ Parent ☐ Guardian

**5. Representative Signature:**

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Signature of Member Representative\*

Date: \_\_\_\_\_

\* Relationship to Member: ☐ Parent ☐ Guardian ☐ Other – Please Specify

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