Authorized Representative Designation Form

You may have someone else act on your behalf in an appeal, including an attorney, if you wish. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form from you telling us who you want to represent you. If you need help with this form, please call Member Services at **833-838-2593 (TTY 711)** Monday through Friday, 8 a.m. to 5 p.m. Central time. Return this this form to us at:

Healthy Blue Grievance and Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax: 877-881-1305

I,_____ want the following person
(Printed Name of Member)

_____ to act for me in my appeal or grievance.

I have talked to this person, and they agree to represent me in the process. I understand that personal medical information related to my appeal or grievance may be disclosed to my representative.

1. Name of Representative (Please Print):

_____

2. Address of Representative:

_____
Street Address or PO Box Apt #

_____ _____
City State Zip Code

( )_____ ( )_____
Phone Number: Daytime Phone Number: Evening

3. Brief description of the appeal or grievance about which this Representative will be acting on my behalf:

_____

_____

_____

4. Signature of Member (or Parent/Guardian)* Date:

_____ _____

* Relationship to Member: ☐ Self ☐ Parent ☐ Guardian

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