



AUTHORIZED REPRESENTATIVE DESIGNATION

You may have someone else act on your behalf in an appeal. 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 from Arizona Complete Health
Appeals Department
PO Box 277610
Sacramento, CA 95827
Phone 1-866-918-4450 (TTY: 711)
Fax 1-877-615-7734

I, _____ want the following person to
(Printed Name of Member)
act for me in my Appeal. I understand that personal medical information related to my appeal 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 for which the Representative will be acting on my behalf (Include Authorization Number) :

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