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 from Louisiana Healthcare Connections
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: 1-833-635-0450 (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 #

_____
City | State | Zip Code

( ) ( )
_____
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

_____