



FROM  **coordinated care**  
1145 Broadway, Suite 300  
Tacoma, WA 98402

### Authorized Representative Designation

We want you to know that you may have someone act on your behalf in an appeal. The person you list below will be designated as your representative for the appeal. We will not be able to provide information to or accept information from another individual besides your doctor until we receive this authorization.

I, \_\_\_\_\_, want the following person to act for me in my appeal. I understand that personal medical information related to my appeal may be disclosed to my representative.

Name and Address of Representative (please print):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address, including Apartment Number or Post Office Box

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Phone Numbers of Representative:

(\_\_\_\_) \_\_\_\_\_  
Daytime Phone Number

(\_\_\_\_) \_\_\_\_\_  
Evening Phone Number

Brief description of the appeal for which the representative will be acting on my behalf:

Member Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

If not member, relationship to member: \_\_\_\_\_ Parent \_\_\_\_\_ Guardian

Member's Date of Birth: \_\_\_\_\_ Member's ID Number: \_\_\_\_\_

Please return this completed form to:

Ambetter from Coordinated Care  
Appeals Department  
1145 Broadway, Ste. 300  
Tacoma, WA 98402

Phone: 877-687-1197  
TTY: 877-941-9238  
FAX: 855-218-0589

1 877 687 1197

TTY: 1 877 941 9238

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