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 Arkansas Health & Wellness
Appeals Department
PO Box 25538
Little Rock, AR 72221
Phone 1-866-617-0390
(TTY/TDD 1-877-617-0392)
Fax 1-866-811-3255

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**