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AMB19-AR-H-066

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 and Wellness
ATTN: Appeal Department
PO Box 25538
Little Rock, AR 72221
Phone: 1-877-617-0390 TDD/TTY: 1-877-617-0392
Fax 1-866-811-3255

I, ______________________________ want the following person ______________________________
(Printed Name of Member) *(Printed Name of Representative)*

to act for me in my Appeal. I understand that personal medical information related to my appeal may be disclosed to my representative.

Please print.

Member DOB:	Member ID:
Name of Representative (Please Print):	Relationship to Member: ☐ Self ☐ Parent ☐ Guardian ☐ Other - Please Specify:
Address of Representative:	
Representative's Phone Number: Daytime	Representative's Phone Number: Evening
Brief description of the appeal for which the Representative will be acting on member's behalf:	

X
....
*Signature of Member (or parent/guardian)** *Date*
** Relationship to Member:* ☐ *Self* ☐ *Parent* ☐ *Guardian*

X
....
*Signature of Member Representative** *Date*
** Relationship to Member:* ☐ *Self* ☐ *Parent* ☐ *Guardian* ☐ *Other – Please Specify*