Appointment of Authorized Representative*

You can represent yourself, or you may ask another person to act as your authorized representative, including your provider. You may revoke this authorization at any time by giving written notice to PEHP (Note: You do not have to fill this out if you are representing a member dependent on your plan, i.e. spouse, child).

PEHP Member ID number: _____

I hereby authorize _____to represent me in appealing

PEHP's decision of: _____.

_____ _____
Signature of patient or parent of minor child Date

Print name: _____

Work/home/cell number:_____

Email address:_____

_____ _____
Signature of Authorized Representative,

Print name:_____

Address of Authorized Representative: _____
_____

Email address:_____

Daytime Phone: _____

*Attach this form to the Appeal Filing Form.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-765-7347 (TTY: 711)