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:

Peach State Health Plan
Appeal Department
1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

Phone 1-877-687-1180
TDD/TTY 1-877-941-9231
Fax 1-866-532-8855 (Grievance/Appeals/Complaint)

I, _____ want the following person to act for me in my
(Printed Name of Member)
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 _____

Phone Number: Daytime _____ Phone Number: Evening _____

3. Brief description of the appeal or grievance/complaint for which the Representative will be acting on my behalf:

_____

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: _____