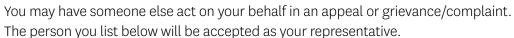
Authorized Representative Designation





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)

ambetter. FROM | peach state

health plan.

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: Ev	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:			