PacificSource Community Solutions
PO Box 5729, Bend, OR 97708-5729
800-431-4135, TTY: 711. We accept all relay calls.
PacificSource.com/Medicaid

Appointment of Representative Statement

Member Name:	
PacificSource Community Solutions' Member ID Number:	
Provider:	
Dates of Service:	
Health Plan:	*PacificSource Community Solutions*

I give _____ my consent to act on my behalf for the appeal or grievance filed with PacificSource Community Solutions. I know that my health records used for my appeal or grievance may be shared with this person.

Signature: _____

Date: _____

This section to be completed by Appointed Person

I, _____ accept the above duty.
(Appointed Person)

Address: _____

Phone number:_____

Email:_____

Signature: _____

Date: _____

Usted puede recibir este documento en otro idioma, impreso en una letra más grande o de otra manera que sea mejor para usted. También puede solicitar un intérprete. Esta ayuda es sin costo. Llame al 800-431-4135 o por TTY al 711. Aceptamos llamadas del servicio de retransmisión.

You can get this document in another language, large print, or another way that's best for you. You can also request an interpreter. This help is free. Call 800-431-4135 or TTY: 711. We accept all relay calls.