DESIGNATION OF AUTHORIZED REPRESENTATIVE

PacificSource Health Plans
Attn: Grievance Review
PO Box 7068
Springfield, OR 97475

MEMBER INFORMATION

Member name: ______________________________ **Member ID:**________________________________

Street address:____

City:______________________________ **State:**________________ **Zip code:**___________________

GRIEVANCE REVIEW

I grant *(provider or entity)* ______________________________________the authority to act on my behalf in pursuing and appealing PacificSource's benefit determination with regard to: *(identify the specific issue you are appealing)*

____

____

____

____

____

I understand that I may revoke this authorization at any time by notifying PacificSource Health Plans at the address below. I also understand that revoking this authorization does not affect my right to appeal. Unless revoked by me, this authorization will be in force and effective until the issue stated above is resolved as requested by my authorized representative or until I have exhausted my rights to appeal the issue.

I have reviewed and I understand this authorization.

Signature: ____ **Date:** __________________________

Relationship to member: ☐ *Self* ☐ *Parent* ☐ *Legal guardian** ☐ *Holder of Power of Attorney**

**Please attach legal documentation if you are the legal guardian or holder of power of attorney.*

Mail to: PacificSource Health Plans
Attention: Grievance Review
PO Box 7068
Springfield, OR 97475

If you have questions about this form, or the appeals process, you are welcome to contact our Customer Service Department:

Oregon	888.977.9299 (toll-free)
Idaho	800.688.5008 (toll-free)
Montana	877.590.1596 (toll-free)
En Espanol	800.624.6052, Ext. 1009 (toll-free)
Email	cs@pacificsource.com