Designation of Authorized Representative Form

PacificSource HEALTH PLANS

Member information

Member name _____ Member ID number _____

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.

Member signature _____ Date _____

Mail or fax this form

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

Fax: 541-225-3628

Questions?

If you have questions about this form or the appeals process, please call Customer Service at **888-977-9299,** TTY: 711. We accept all relay calls.