



AUTHORIZED REPRESENTATIVE DESIGNATION

You may have someone else act on your behalf in an appeal. 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:

Ambetter from Superior HealthPlan
ATTN: APPEALS DEPARTMENT
5900 E Ben White Blvd.
Austin, TX 78741
Phone 1-877-398-9461 (Relay Texas/TTY
1-800-735-2989) Fax 1-866-918-2266

I, _____ want the following person to
(Printed Name of Member)

act for me in my Appeal. I understand that personal medical information related to my appeal 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 Code**

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Phone Number: Daytime **Phone Number: Evening**

3. Brief description of the appeal for which the Representative will be acting on my behalf (Include Authorization Number) :

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