AUTHORIZED REPRESENTATIVE DESIGNATION

You may have someone else act on your behalf in an appeal or grievance/complaint. 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 form by Mail: **CareSource**
ATTN: Indiana Member Appeals
P.O. Box 1947
Dayton, OH 45401-8738

Return form by FAX: 1-844-417-6262

I, _____ want the following persons 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.

Name of Representative (Please Print)

_____

Address

_____

Street Address or P.O. Box City State Zip

Phone

_____

Daytime Phone Evening Phone

Brief description of the appeal or grievance/complaint for which the Representative will be acting on my behalf:

Member Signature:_____
Member Date of Birth _____
Member ID:_____

Representative Signature:_____ Date _____

Relationship to Member (circle one) Self Parent Guardian
Other: _____

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