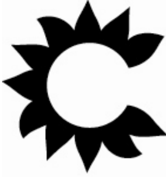

COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

Consent to file an appeal on behalf of the member.
Member must sign this form in the “signature” section below.

I ________________________________, member # __________________ would
(please print name)

like _________________________ to be my authorized representative and file
<doctor or representative’s name>

an appeal for me with Community Health Plan of Washington

for _____________________.
<service>

Please mail this signed form in the self addressed stamped envelope to:

Community Health Plan of Washington
720 Olive Way, Suite 300
Seattle, WA 98101

Or fax to 206-613-8984

SIGNATURE: ________________________________ DATE: ___________________

(If signature by a personal representative of the member, please complete the following)

Personal Representative's Name:

____

Relationship to member: ☐ Parent (for children 13 years of age or younger)
☐ Legal Guardian* ☐ Power of Attorney*

* Please attach legal documentation if you are the legal guardian or holder of a Power of Attorney.