



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.

Consent for an authorized representative 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 an
<doctor or other representative's name>

appeal for me with Community Health Plan of Washington for _____ .
<service>

This consent is for the purpose of pursuing my appeal rights regarding this issue only and will remain in effect for all levels of the appeal process.

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 206-613-8983

SIGNATURE: _____ **DATE:** _____

If the signature above is 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.