Member Consent: Authorize a Representative

Use this form to give consent for someone to appeal a coverage decision on your behalf. Your Authorized Representative can be your doctor, a legal representative, or another person you choose to communicate with Community Health Plan of Washington (CHPW) about your appeal request.

Complete, sign, and send this form to CHPW by email, fax, or mail:

Email (preferred)**:** AppealsGrievances@chpw.org, **Fax:** 206-613-8984

Mail: Community Health Plan of Washington
1111 3rd Ave, Suite 400
Seattle, WA 98101

Section A: Member Information *(Required)*

Member First and Last Name	CHPW Member ID Number	
Mailing Address	Phone Number (with area code) ( ) -	
City	State	ZIP Code
Email (optional)	Fax (optional) ( ) -	
Member Signature		Date Signed (mm/dd/yyyy) / /

We will send all communications about your appeal to your Authorized Representative. They will be your main contact during the appeals process. This consent will expire when the final decision on the appeal is issued. If you change your mind after sending us this form and no longer wish for them to act on your behalf, you must contact CHPW by phone or in writing to revoke their status as your representative. CHPW does not cover any fees or payments to your representatives.

Section B: Authorized Representative Information *(Required)*

Representative First and Last Name		
Relationship to Member (Provider, attorney, relative, etc.)		
Mailing Address	Phone Number (with area code) ( ) -	
City	State	ZIP Code
Email	Fax (optional) ( ) -	
Representative Signature		Date Signed (mm/dd/yyyy) / /

If signed by someone other than the provider or the dependent member's parent, you must provide a copy of the following to act on the member's behalf:

- A copy of a power of attorney (health care, general, or durable) **OR**
- A court order or other legal documentation that shows custody or authority of the legal representative to act on the member's behalf.

Section C: Service being appealed

Please provide as much information as you can about what you are appealing. If you have a denial letter, include the date on that letter. This will help us begin our review more quickly.

Service or Medication Name	Date of Planned Service / /
Authorization Request Cert # (from your denial letter)	Date on Denial Letter / /