APPOINTMENT OF REPRESENTATIVE FORM

Please fill out this form only if you would like to choose someone to represent you in your appeal. Be sure to sign your name. An appeal can be requested when you have been denied a service. Please fax or mail this form to the number or address below.

You must tell your provider if you select him or her to be your appeal representative.

Note: Please ask the provider to submit a formal request for an appeal. All medical notes should be submitted to support the request.

To Peach State Health Plan Appeals and Grievance Department:

I _____ give consent for_____ to
(Member's Name or Parent/Guardian) (Provider's Name or Other Representative)

act as my representative in the filing and processing of an administrative review (appeal).

_____

(Signature of Member or Parent/Guardian)

_____

(Print Name)

_____

(Member's Medicaid Number)

THIS FORM IS NOT A FORMAL APPEAL REQUEST. Peach State Health Plan requires a verbal appeal request or written appeal request. Please call member services at 1-800-704-1484 to make a verbal appeal request. Also, the contact information is below to mail or fax your written appeal request.

Appeal Phone (Verbal Request): 1-800-704-1484

Appeal Address and Fax Number (for written request):

Appeal Address:
Peach State Health Plan
Appeals and Grievance Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
Fax: 1-866-532-8855

Do you need help understanding this? If you do, call Peach State Health Plan's Member Services line at 1-800-704-1484. If you are hearing impaired, call our TDD/TTY 1-800-255-0056. To get this information in large font or have this information read to you over the phone, call Member Services.