delaware first health

APPEAL AND GRIEVANCE AUTHORIZED REPRESENTATIVE DESIGNATION

You may choose someone to act for you during your appeal or grievance. The person you name below will be your official representative. We cannot talk with anyone about your appeal or grievance until we receive this completed form. If you need help filling out the form, call us at the phone number below.

Send the completed form to:

Delaware First Health
Appeal & Grievance Coordinator
P.O. Box 10353
Van Nuys, CA 91410-0353
Fax: 1-833-525-0054
Phone (toll-free): **1-877-236-1341** (TTY: **711**)

I, _____ (member name), choose the person named below to represent me in my appeal or grievance. I have talked with this person, and they agree to help me. I understand that personal medical information may be shared with my representative.

1. Name of Representative (Please Print): _____

2. Address of Representative:

_____
Street Address or PO Box Apt #

_____ _____ _____
City State Zip Code

_____ _____
Phone Number: Daytime Phone Number: Evening

3. Brief description of the appeal or grievance for which this representative will be acting on my behalf:

4. Signature of Member (or parent/guardian)*

Signature: _____ Date: _____

*Relationship to Member: ☐ Self ☐ Parent ☐ Guardian/DPOA

Note: This form cannot be signed by a provider.