APPEAL AND GRIEVANCE AUTHORIZED REPRESENTATIVE DESIGNATION

You may have someone else act on your behalf in an appeal, including an attorney if you wish. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form. If you need help with this form, call us at the number below. Return this this form to us at:

Sunflower Health Plan
Quality Department
8325 Lenexa Drive, Suite 200
Lenexa, KS 66214
Fax 1-888-453-4755
Phone (toll-free) 1-877-644-4623
TTY 711

I,_____ want the following person
(Printed Name of Member)

_____ to act for me in my appeal or grievance. I have talked to this person and he/she agrees to represent me in the process. I understand that personal medical information related to my appeal may be disclosed to 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 this Representative will be acting on my behalf:

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

_____ Date: _____

* Relationship to Member: ☐ Self ☐ Parent ☐ Guardian