APPEAL AND GRIEVANCE AUTHORIZED REPRESENTATIVE DESIGNATION

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

Send the completed form to:

Sunflower Health Plan – Appeals Department
P.O. Box 10287
Van Nuys, CA 91410-0287
Fax 1-888-453-4755
Phone (toll-free) 1-877-644-4623; 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 about my appeal 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 for which this representative will be acting on my behalf:

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

_____ Date: _____

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

Note: This form cannot be signed by the provider.