Appeal Representative

ALLOW SOMEONE TO HELP WITH YOUR APPEAL

You may have someone else act on your behalf in an Appeal. The person you list below will be accepted as your Representative. We cannot speak with anyone acting on your behalf until we receive this form.

I, _____, want the following person to act for me in my appeal. I understand that my personal health information related to my appeal may be given to my Representative.

Member Medicaid #: _____

Representative Name: _____

Representative's Address: _____

City: _____ State: _____ Zip: _____

Representative's Phone: _____

Brief description of the appeal for which Appeal Representative will be acting on your behalf:

_____

_____

_____

_____

Signature of Member (or Guardian): _____ Date: _____

*Relationship to Member: ☐ Self ☐ Parent ☐ Guardian

Representative's Signature: _____ Date: _____

*Relationship to Member: ☐ Self ☐ Parent ☐ Guardian ☐ Other: _____

SEND YOUR COMPLETED FORM TO:

Louisiana Healthcare Connections, ATTN: Appeals
8585 Archives Avenue, Suite 310, Baton Rouge, LA 70809

Or fax to: 1-877-401-8170

HAVE QUESTIONS OR NEED HELP?

Call us at 1-866-595-8133 (hearing loss: 711), Monday through Friday, 7 a.m. to 7 p.m.