Personal Appeal Representative Form

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 on your behalf until we receive this form. Return to us at:

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

I, _____ want the following person to act for me in my Appeal.
[PRINTED NAME OF MEMBER]

I understand Personal Health Information related to my Appeal may be given to my Appeal Representative.

Name of Appeal Representative: _____
[PLEASE PRINT]

Address of Appeal Representative:

Street/P.O. Box/Apartment # _____

City _____ State _____ Zip Code _____

Phone (_____) _____ Phone (_____) _____
[DAYTIME] [EVENING]

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

_____

_____

_____

Member Signature: _____
[SIGNATURE OF MEMBER, PARENT OR GUARDIAN*]

**Relationship to Member:* ☐ SELF ☐ PARENT ☐ GUARDIAN*

Appeal Representative Signature: _____
[SIGNATURE OF APPEAL REPRESENTATIVE*]

**Relationship to Member:* ☐ SELF ☐ PARENT ☐ OTHER *(Please specify)*

_____

louisiana healthcare connections™

8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

1-866-595-8133
Hearing Loss: 711
Monday–Friday, 7 a.m. to 7 p.m.

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