Appointment of Representative

Member name: _____

Member ID number: _____

Member instructions

Complete and sign this form if you want to appoint someone to file your request for an appeal on your behalf. You may appoint any person to act as your representative in filing an appeal, including any physician or other health care professional. We require you to complete this form before we can start the appeal process.

Appeal request

If you are not an eligible member or if the appeal request was received after the deadline, we will close the request without further review.

Representative

I appoint _____ as my representative for UnitedHealthcare payment reconsideration or service authorization. I understand this representative may receive personal medical information related to my appeal.

Arizona Health Care Cost Containment System (AHCCCS) Regulation A.A.C. R9-34-208(B)

An authorized representative, including a provider, acting on behalf of the enrollee, with the enrollee's written consent, may file an appeal or request a State Fair Hearing on behalf of an enrollee. A provider is permitted to file a grievance with a contractor at the contractor's discretion.

Print member name:	
Member's signature:	**Date:**

Please return completed form to:

UnitedHealthcare Community Plan
1 East Washington, Suite 900
Phoenix, AZ 85004

United Healthcare® Community Plan