Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

APPOINTMENT OF REPRESENTATIVE FORM
For use with GRIEVANCES and/or APPEALS for COMMERCIAL MEMBERS

Member Name: Member CHP ID Number:

Subscriber Name (if different than above): Subscriber CHP ID Number:

Description of Grievance and/or Appeal:

I appoint this individual: _____ to act as my representative in connection with my grievance and/or appeal with Capital Health Plan. I authorize this individual to make any request; to present or elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to this grievance and/or appeal may be disclosed to the representative listed below.

This Appointment of Representative Form is valid only for matters related to this specific grievance and/or appeal.

_____ _____

Signature of Member Seeking Representation Date

I _____, hereby accept the above appointment to act as this individual's representative in this grievance and/or appeal with Capital Health Plan.

_____ _____

Signature of Representative Date

Representative's contact information:

Address: _____

_____

Phone: _____

Please return this form to:
Capital Health Plan
Grievances and Appeals
P.O. Box 15349
Tallahassee, FL 32317-5349
Fax: (850) 383-3413