



HEALTHCARE COOPERATIVE

# AUTHORIZED REPRESENTATIVE FORM FOR INQUIRY, GRIEVANCE AND APPEAL

## Part A: Member Information

I appoint the Authorized Representative (AR) designated below to file and pursue a grievance or appeal, or make an inquiry, on my behalf. This means that Common Ground Healthcare Cooperative (CGHC) may release information to my AR, including medical, claims and enrollment information. I understand that by allowing my AR to pursue this grievance or appeal on my behalf, that I am exhausting those rights under my policy.

Member Last Name	Member First Name	Preferred Phone # (Including area code)
Member Date of Birth	Member ID Number	
Member Street Address		
City	State	Zip Code

## Part B: Person or Company who is Authorized Representative

Member Last Name	Member First Name	Preferred Phone # (Including area code)
Email Address	Relationship	
Street Address		
City	State	Zip Code

## Part C: Type of Information (Nature of your appeal or grievance)

*Describe your issue and whether you wish to have any limitations on disclosure. If not, information will be disclosed to your AR in the same manner it would be disclosed to you.*


## Part D: Signature

I have read the contents of this form. I understand, agree and allow CGHC to release my information. I understand that I am not required to sign this form and it will not impact my right to benefits under my policy. I have the right to withdraw this approval at any time by giving notice to CGHC. I understand that once information is released under this agreement, it may not be protected by the person to whom it is released. I am entitled to a copy of this form.

Member Signature	Date
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