



Appointment of Representative

You or someone on your behalf may contact Abrazo Advantage Health Plan (AAHP) to request a coverage determination, pharmacy exception, grievance and/or an appeal.

You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want to name someone to act for you, then you and the person you want to act for you must sign and date the "Appointment of Representative" form *BELOW*. When completed, this form gives this person legal permission to act as your authorized representative. A valid representative has all the grievance and appeal rights and responsibilities of an AAHP member.

Please send (or deliver in person) this completed form to:

Abrazo Advantage Health Plan
Attention: Pharmacy Department
7878 North 16th Street, Suite 105
Phoenix, AZ, 85020

You may fax this completed form to (602) 674-6655 or (866) 832-5469 if outside of Maricopa County.

Please call us at (602) 924-3900 or (888) 864-1114 (for TTY: [602] 824-3909 or [800] 489-1472) to learn how to name your authorized representative. We are open 8:00 a.m. to 8:00 p.m. seven days a week.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. Please call AAHP for more information about these resources.

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ABRAZO ADVANTAGE HEALTH PLAN RECONSIDERATION PROCESS

APPOINTMENT OF REPRESENTATIVE STATEMENT

Enrollee Name

Medicare/HIC Number

Provider

Dates of Service

Health Plan

I do hereby swear that I am the above-mentioned enrollee or have the legal authority to appoint a representative for the above-mentioned enrollee. I do hereby appoint the following individual _____ to act as my representative in requesting a reconsideration from the above-referenced health plan and/or the MAXIMUS CHDR, as designated external appeal agent of the Centers for Medicare and Medicaid Services, regarding the services for which the above-referenced health plan has denied payment or authorization.

Signature

Date

I, _____ hereby accept the above appointment.
(Appointed Representative)

Signature of Appointed Representative

Date