[Logo[P1]]
[Enrollment_Address2[115]]

APPOINTMENT OF REPRESENTATIVE

Date: **Member number:**

Name: **Reference/Case number:**

PART 1 --- APPOINTMENT OF REPRESENTATIVE (to be filled out by member)

I allow_____to act for me when filing a grievance, claim or appeal.
(Name of person you want as your representative)

The person I have named can act for me when giving or receiving any information about my grievance, claim or appeal. This includes personal medical information.

Member:	Date:
Street Address:	Phone (with area code):
City:	State: ZIP Code:

PART 2 --- ACCEPTANCE OF APPOINTMENT (to be filled out by Representative)

I,_____accept the appointment. I will act on behalf of the
(Name of person who will be member's representative)
member to file a grievance, claim or appeal.

Relationship to Member: (Must be 18 or older)	
Representative Signature:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

This authorization is good for one year from the date you sign this form unless you tell us the following:

Date: _____/_____/_____or Event: _____
Month Day Year

If you sign the form and are not the member or the person listed as the responsible party for the member, a legal document is required to be on file with WellCare of Kentucky. Per our Compliance Dept: a specific system limitation was created for all members over the age of 18. To ensure that we do not speak to someone other than a member, unless we have received the actual POA, Guardianship documents.

Please fill out this form. Mail, fax or deliver it to the address below:

[WellCare Health Plans[131]]
[P.O. Box 31372
Tampa, FL 33631-3372[115]]
[Fax - 813-464-8413[124]]

Member Signature: _____ Date: _____

WellCare of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-389-9457 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-389-9457 (TTY: 711).

注意：如果您說使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-389-9457 (TTY：711)。