APPOINTMENT OF REPRESENTATIVE FORM
FOR USE WITH GRIEVANCES FROM COMMERCIAL MEMBERS

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

Description of Grievance: (for example, practitioner's name, facility, dates of service, complaint issue)

I do hereby swear that I am the above-mentioned Capital Health Plan, Inc., member or an authorized representative of the above-mentioned member.

I appoint the following individual: ____
to act as my representative in pursuing this appeal/grievance with Capital Health Plan, Inc. I authorize this individual to present or give any evidence to Capital Health Plan, and to obtain or request information related to the appeal/grievance from Capital Health Plan. I understand this means that the appointed individual will have access to my personal health information that is related to the matter under appeal.

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

____ ______________________
Signature – Member Date

I accept the appointment to act as this individual's representative in this appeal/grievance with Capital Health Plan. I understand this Appointment of Representative Form is valid only for matters related to this specific grievance/appeal.

____ ______________________
Signature – Representative Date

Representative's contact information:

Address: ________________________________

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Phone: __________________________________

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

QIMT approved 8/3/06