WellCare® Health Plans

WELLCARE OF NEW JERSEY HEALTH PLAN

APPOINTMENT OF REPRESENTATIVE FORM

Member's Name:	Medicaid Number:

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

I allow _____ to act for me when filing a grievance, claim or appeal. This person can give or receive any information about my grievance, claim or appeal. That includes personal medical data.

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

PART 2 – ACCEPTANCE OF APPOINTMENT TO REPRESENT (to be filled out by the representative)

I, _____, accept the appointment to represent <member name>. I will act for the member to file a grievance, claim or appeal.

Relationship to Member:		
Representative Signature:	Date:	
Street Address:	Phone Number (with area code):	
City:	State:	ZIP Code:

This document contains important information. To receive it in another language or have it translated, please call us at **1-888-453-2534**, TTY users should call **1-877-247-6272,** Monday–Friday 8 a.m. to 6 p.m.

Este documento se encuentra disponible en idiomas alternativos. Por favor llame a Servicio al Cliente al número indicado anteriormente si desea recibir esto en un idioma alternativo.