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Appointment of Representative Statement

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito **1-800-813-2000**. Los usuarios del servicio TTY pueden llamar al 711.

*You can get this letter in another language, large print, or another way that's best for you. Call **1-800-813-2000** (TTY 711).*

Member Name

Medicaid Number

Provider

Dates of Service

Kaiser Foundation Health Plan of the Northwest
Health Plan

I give _____ my consent to act on my behalf for the case filed with Kaiser Foundation Health Plan of the Northwest. I know that my health records used for my appeal may be shared with this person.

Signature

Date

This section to be completed by Appointed Person

I, _____ accept the above duty.
(Appointed Person)

Signature of Appointed Person

Date