PacificSource Community Solutions
PO Box 5729, Bend, OR 97708-5729
800-431-4135, TTY: 711. We accept all relay calls.
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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***