Appointment of an Authorized Representative form

You may have someone act on your behalf in an appeal. The person you list below will be your authorized representative. We cannot speak with anyone on your behalf until we receive your written approval. Please send your written approval to:

Health Plan of Nevada
Attn: Customer Response and Resolution Department
P.O. Box 14865
Las Vegas, NV 89145

I, _____ want the following person to act for me in my appeal. (Member Name printed)

I understand that Personal Health Information related to my appeal may be given to my authorized representative.

A. Please print the name of your authorized representative _____

Relationship of the representative to the member_____

B. Address of authorized representative:

P.O. Box/Street/Apartment # _____

City _____ State _____ZIP Code_____

Telephone Number _____

C. Brief description of the appeal being submitted by your authorized representative:

D. Authorized Representative Signature _____ Date_____

E. Member Signature_____ Date_____

Relationship to member: ☐ Self ☐ Parent ☐ Guardian

This form is valid during the appeal indicated in item **C**. Once the appeal is complete, this form is no longer valid.