Authorized Representative Designation

You may have someone else act on your behalf in an appeal. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form. Return to us at:

IlliniCare Health
Appeals Coordinator
999 Oakmont Plaza Drive
Suite 400
Westmont, IL 60559

Phone: 866-329-4701
TDD/TTY: 866-811-2452
Fax: 877-668-2075

1. I want the following person to act for me in my appeal:
Name of Representative: _____

2. Address of Representative:
Street Address or PO Box: _____ Apt #_____
City: _____ State: _____ Zip Code: _____
Daytime Phone Number: ___-____ - ______ Evening Phone Number: ___-____ - ______

3. Brief description of the appeal for which the Representative will be acting on your behalf:

_____
_____
_____
_____

4. Member Signature:

_____ _____
Printed Name of Member (or legal representative)* Date

_____ _____
Signature of Member (or legal representative)* Date

*** Relationship to Member:**
☐ Parent ☐ Guardian ☐ Other – Please Specify _____