



Designation of Authorized Representative Form

You have the right to choose someone to represent you during your Appeal or Grievance with Neighborhood Health Plan (NHP). If you would like someone to represent you, you must complete this form and return it to us. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records, and speak to your representative on matters related only to your Appeal or Grievance. You may revoke this designation at any time by sending us a written request.

Please note that if we do not receive a signed *Designation Authorized Representative Form* by the deadline for resolving your Appeal or Grievance, we may dismiss your Appeal or Grievance and, if we do, we will notify you of such in writing.

Please read this form carefully and fill it out completely. Please print or type. If printing, please use a pen.

1. Required Information

Subject of Appeal:	
Member name:	NHP Member ID number:
Member address:	Date of birth:
Phone number:	
Name of member's Appeal (Grievance) representative:	Phone:
Address:	Fax:

2. Required Signatures

Member/Guardian signature _____ Date _____

In the event that the member is a minor or otherwise legally incompetent, please provide the name, address, and relationship to the member of the person who is signing the designation letter.

Name _____ Relationship _____

Address _____

Please mail this completed form to:
 Member Service Center—Appeal Team
 Neighborhood Health Plan
 253 Summer Street, Boston MA 02210-1120
Or fax to: 617-526-1985

If you have any questions about completing this form, please call NHP's Member Service Center at **1-800-462-5449**.