AUTHORIZED REPRESENTATIVE FORM

Member Name: ___________________________ Member ID#:_____________________

Date of Birth: ____________________ Address: _________________________________

City: _____________________________ State: __________ Zip Code:_______________

Phone #: ________________________

I hereby authorize the following person to act as my Authorized Representative for the above referenced Appeal. I understand that this person may be given health or payment information related to the above referenced Appeal. Well Sense Health Plan will act on this information until I revoke or amend this authorization. This authorization expires on the date Well Sense Health Plan sends out the Appeal decision notice related to this matter.

Authorized Representative Name: ____

Phone #:____

Member/Legal Representative Signature: ______________________________________

Date: ______________________________________