meridianhealth
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MERIDIANHEALTH AUTHORIZED REPRESENTATIVE DESIGNATION

To have someone else act on your behalf in an appeal, complete and return this form. The person listed will be accepted as your authorized representative. We are unable to speak with anyone on your behalf unless this form is completed, signed, and returned to us.

MeridianHealth
Attn: Grievance and Appeals Dept.
PO Box 44287
Detroit, MI 48244
Fax: 833-383-1503

1. I hereby authorize the following person to act on my behalf in the filing and processing of my appeal with MeridianHealth:	
Name of Authorized Representative	
2. Brief description of the service and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:	
3. Address of Authorized Representative	
Street Address or PO Box	Apt #
City State	Zip Code
( )	( )
Phone Number: Daytime	Phone Number: Evening
4. Member Signature	
Printed Name of Member (or legal representative)*	Date
Signature of Member (or legal representative)*	Date
* Relationship if other than the Member: ☐ Parent ☐ Guardian ☐ Conservator ☐ Other – Please Specify _____ Please note you may revoke this authorization at any time.	