COMMON GROUND
HEALTHCARE COOPERATIVE

AUTHORIZED REPRESENTATIVE FORM FOR INQUIRY, GRIEVANCE AND APPEAL

Part A: Member Information

I appoint the Authorized Representative (AR) designated below to file and pursue a grievance or appeal, or make an inquiry, on my behalf. This means that Common Ground Healthcare Cooperative (CGHC) may release information to my AR, including medical, claims and enrollment information. I understand that by allowing my AR to pursue this grievance or appeal on my behalf, that I am exhausting those rights under my policy.

Member Last Name	Member First Name	Preferred Phone # (Including area code)
Member Date of Birth		Member ID Number
Street Address		
City, State Zip Code		

Part B: Person or Company who is Authorized Representative

Last Name	First Name	Preferred Phone # (Including area code)
Email Address		Relationship
Street Address		
City, State Zip Code		

Part C: Type of Information (Nature of your appeal or grievance)

Describe your issue and whether you wish to have any limitations on disclosure. If not, information will be disclosed to your AR in the same manner it would be disclosed to you.

Part D: Signature

I have read the contents of this form. I understand, agree and allow CGHC to release my information. I understand that I am not required to sign this form and it will not impact my right to benefits under my policy. I have the right to withdraw this approval at any time by giving notice to CGHC. I understand thatonce information is released under this agreement, it may not be protected by the person to whom it is released. I am entitled to a copy of this form.

Member Signature		**Date**	

Email the completed form to grievance@CommonGroundHealthcare.org

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