



Health Net Options Plus

Health Net Life Insurance Company
Appeals & Grievance Unit
13221 SW 68th Parkway, Suite 200
Tigard, Oregon 97223

APPOINTMENT OF REPRESENTATIVE STATEMENT

Member Name: [Member Name]
Reference Number: [Reference Number]
Member Number: [Member Number]

I _____ do hereby swear that I am the above-mentioned enrollee or have the legal authority to appoint a representative for the above-mentioned enrollee. I do hereby appoint _____ to act as my representative in requesting a reconsideration from the above-referenced health plan and/or the MAXIMUS Federal Services, as designated external appeal agent of the Centers for Medicare and Medicaid Services, regarding the services for which the above-referenced health plan has denied payment or authorization.

Signature

Date

I, _____, hereby accept the above appointment.
(Appointed Representative)

Signature of Appointed Representative

Date