NextLevelHealth
A healthier you. A healthier community.

Date

Authorized Representative Form for Grievances and Appeals

As a member of NextLevel Health you may authorize (for example a family member, friend or health care provider) to act as your representative in your grievance or appeal process. If you would like to authorize someone to act on your behalf, please provide the requested information, sign the form below and have your authorized representative sign as well.

Please note you may revoke this authorization at any time.

Member Last Name	**Member First Name**		**MI**
Member Address	**City**	**State**	**Zip Code**
Email Address	**Home Phone**	**Mobile Phone**	
Name of Provider	**Provider's Address**		
Medicaid Identification Number	**Member's Date of Birth**		
Brief description of the service(s) and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:			

I, _____ do hereby name the following person

_____ to act as my authorized representative in requesting

(check one) □□ a standard appeal □□ an expedited appeal a grievance

Authorized Representative Name	**Relationship to Member**	**Phone**
Address	**City/State**	**Zip Code**

Member Signature _____ Date

Authorized Representative Signature _____ Date

I have read this Authorized Representative Form. I understand that, by signing this form, I am confirming my authorization that the above individual may act on my behalf during this grievance or an appeal. I do understand that I may revoke this authorization at any time. I understand that I must revoke this authorization request in writing. **Please note: This authorization will automatically expire upon completion of the grievance or appeal file on your behalf**.

Please send this form to the following:

NextLevel Health
Attention: Appeals & Grievance Department
303 W. Madison Street, Ste. 800
Chicago, IL 60606
Grievances@nlhpartners.com
Fax: (312)767-2544