CHA
Health Plan

clearhealthalliance.com/member

Authorized Representative Form

An **authorized representative** is a person who has **written permission** (your OK) to make decisions about your healthcare for you. You (the member), a parent, or a legal guardian gives them permission. Your authorized representative can make choices about your healthcare, your enrollment and disenrollment, and filing appeals or grievances with Clear Health Alliance. You can choose your primary care provider (PCP) as your authorized representative.

By signing this form, you give the OK to the person below to make choices for you. You'll be responsible for any decisions your authorized representative makes for you during the time you let them act for you. They make decisions for you from the date on this signed form until the date we get your written request to end this permission — or the end date of a specific event (like a service or item being appealed), whichever is first.

You can take this permission back anytime. Write to us at the address or fax number below saying you want to end your permission to have an authorized representative.

Member name: _____
Member ID number: _____
Specific event (the service or item being appealed):
_____

Authorized representative:
Name: _____
Phone number: _____
Address (with street, city, state, and ZIP code):
_____

Signature of member, parent, or legal guardian: _____
Date: _____

Send this form to:
Clear Health Alliance
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax: 866-216-3482

Enclosures: Get help in another language
Nondiscrimination notice