PacificSource Community Solutions, Inc.
PO Box 5729, Bend OR 97708-5729
541.382.5920 800.431.4135
CommunitySolutions.PacificSource.com

Appointment of Representative Statement

_____ _____
Enrollee Name Medicaid Number

_____ _____
Provider Dates of Service

PacificSource Community Solutions
Health Plan

I appoint: _____ to act as my representative in the reconsideration for the services that the Health Plan has denied payment or authorization. I understand that personal medical information related to my appeal may be disclosed to this representative.

_____ _____
Signature **Date**

This section to be completed by Appointed Representative

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

_____ _____
Signature of Appointed Representative ***Date***