Beacon Health Strategies
Designation of Authorized Representative
For Appeals or Grievances

You have the right to chose someone to represent you during your Appeal or Grievance with Well Sense Health Plan (Well Sense). If you would like someone to represent you, you must complete this form and return it to us. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records, and speak to your representative on matters related only to your appeal or grievance. You may revoke this designation at any time by sending us a written request.

Please note that if we do not receive a signed *Designation of Authorized Representative Form* by the deadline for resolving your appeal or grievance, we will dismiss your appeal or grievance, and notify you of such in writing.

Please read this form carefully and fill it out completely. Please print or type. If printing, please use a pen.

1. Required Information

Member name:	Member ID number:
Member address	Date of birth:
Well Sense Member ID Number:	
Phone number:	
Name of member's designated authorized representative:	Phone:
Address:	Fax:

2. Required Signatures

Member/Guardian signature _____ Date _____

In the event that the member is a minor or otherwise legally incompetent, please provide the name, address, and relationship to the member of the person who is signing the designation letter.

Name _____ Relationship _____

Address _____

Please return this completed form by mail to:
Beacon Health Strategies
Appeals Coordinator (Appeals) or Ombudsperson (Grievances)

or by fax to:
781-994-7636