5300 Homestead Rd NE,
Albuquerque, NM 87110
1-844-543-8996

Authorized Representative Designation Form

You may have someone else act on your behalf when you have a grievance or an appeal. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form.

Please return the completed form by mail or fax to the following:

Western Sky Community Care
ATTN: Appeals Department
5300 Homestead Road NE
Albuquerque, NM 87110
Fax: 1-844-320-2479

I,_____
[PRINTED NAME OF MEMBER]

Want the following person to act for me in my grievance and/or appeal. I understand Personal Health Information related to my grievance and/or appeal may be disclosed to **my representative.**

1. **Name of Appeal Representative**_____
[PLEASE PRINT]
2. **Address of Appeal Representative:**
Street/PO Box/Apartment # _____
City_____State_____Zip Code_____
Daytime Phone (____)_____ Evening Phone (____)_____
3. **Brief description of the appeal for which Appeal Representative will be acting on in your behalf:**
_____
_____
4. **Member Signature:**_____
[Signature of Member, Parent or Guardian]* *Date*

***Relationship to Member:** ☐ Self ☐ Parent ☐ Guardian

5. **Appeal Representative Signature:**_____
[Signature of Appeal Representative]* *Date*

Relationship to Member: ☐ Parent ☐ Guardian ☐ Other: _____

For questions, please contact Member Services at 1-844-543-8996, Monday – Friday 8:00 a.m. – 5:00 p.m.

Such services are funded in part with the State of New Mexico