



An AmeriHealth Mercy Company

PO Box 6600 \* Harrisburg, PA 17112
Capital Area 1-888-722-8646; Bedford/Somerset 1-866-773-7891; Blair 1-866-773-7892; Franklin/Fulton 1-866-773-7917; Lycoming/Clinton 1-866-773-7991 \* Fax 717-671-6555

AUTHORIZATION FOR REPRESENTATION

Date of Request Provider ID # (if applies)

Delegate Name

Delegate Address

Organization (if applies) Phone Number

Signature of Delegate Date

On behalf of Member: Name Date of Birth

Address

MA ID#

Community Behavioral HealthCare Network of PA (CBHNP)

By signing this consent form, the above mentioned delegate is allowed to act on behalf of the me/Member during the complaint/grievance process which is addressing the issue of

I may not submit a complaint/grievance concerning the services listed in this consent form unless I rescind this consent in writing with CBHNP. I have been advised that I may take back this request at any time during this complaint/grievance.

If this consent is removed in writing, I may file a complaint/grievance on my/Member's own behalf. I may also, at any time during this complaint/grievance process, give consent again to the above named delegate to act on my/Member's behalf.

Regardless of the outcome of this grievance I/Member will not be held financially responsible.

I have read and understand or have had read to me, to my satisfaction, this consent form.

Member Signature Date

Member Representative Date
(For Minor or legally incompetent Member)

Address of Representative

Relationship to Member