

**DESIGNATION OF  
AUTHORIZED  
REPRESENTATIVE**



**PacificSource Health Plans  
Attn: Grievance Review  
PO Box 7068  
Eugene, OR 97401**

**MEMBER INFORMATION**

**Member name:** \_\_\_\_\_ **Member ID:** \_\_\_\_\_

**Street address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**GRIEVANCE REVIEW**

I grant (*provider or entity*) \_\_\_\_\_ the authority to act on my behalf in pursuing and appealing PacificSource's benefit determination with regard to: (*identify the specific issue you are appealing*)

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I understand that I may revoke this authorization at any time by notifying PacificSource Health Plans at the address below. I also understand that revoking this authorization does not affect my right to appeal. Unless revoked by me, this authorization will be in force and effective until the issue stated above is resolved as requested by my authorized representative or until I have exhausted my rights to appeal the issue.

I have reviewed and I understand this authorization.

**Member signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Mail to: PacificSource Health Plans  
Attention: Grievance Review  
PO Box 7068  
Eugene, OR 97401

If you have questions about this form, or the appeals process, you are welcome to contact our Customer Service Department:

**Oregon** 888.977.9299 (toll-free)  
**Idaho** 800.688.5008 (toll-free)