PIEDMONT
COMMUNITY HEALTH PLAN

APPOINTMENT OF REPRESENTATIVE

Name of Party	Member Number:

Section 1: Representative

To be completed by the party seeking representation

I appoint this individual, _____ to act as my representative in connection with my coverage with Piedmont Community Health Plan and related provisions of evidence of coverage. I authorize this individual to make any request; to present or to elicit evidence; to obtain grievance/appeals information; and to receive any notice in connection with my grievance/appeal, wholly in my stead. I understand that personal medical information related to my grievance/appeal may be disclosed to the representative indicated below.

Member Signature		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____ , hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Virginia Department of Health or Virginia Bureau of Insurance that I am not disqualified from acting as the party's representative.

I am a/an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Signature		Date