



Member Grievance Consent Form

You may have someone else act on your behalf in a grievance request, if you wish. The person you list below will be accepted as your authorized representative. We cannot speak with anyone on your behalf until we receive this form from you telling us who you want to represent you. If you need help with this form, please call Member Services at **833-731-2140 (TTY 711)**, Monday through Friday 7:30 a.m. to 6 p.m. Central time. Return this form to us at:

Wellpoint Grievance and Appeals
4800 Westown Pkwy, Ste 200
Des Moines, IA 50266
Fax: 877-881-1305

Member Name: _____

Member ID: _____

I, _____ give permission for

(Printed Name of Member (or Parent/Guardian))

_____ to request the grievance

(Printed Name of Authorized Representative) on my behalf.

1. Name of Authorized Representative (Please Print):

2. Address of Authorized Representative:

Street Address or P.O. Box _____ Apt # _____

City _____ State _____ Zip Code _____

() _____
Phone Number

Signature of Member (or Parent/Guardian)*: _____

* Relationship to Member: Self Parent Guardian

Date: _____

Without this consent, the grievance will be dismissed.

wellpoint.com/ia/medicaid

