GRIEVANCE, APPEAL, AND FAIR HEARING

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

You may have someone else act on your behalf in a grievance, appeal or fair hearing. By filling this out, you are requesting the person you list below be accepted as your representative.

- *For fair hearings, providers cannot be an authorized representative for an applicant.*
- If an applicant is deceased or becomes deceased during the fair hearing process, you need to contact the Office of Administrative Hearings to for the correct process.
- The organization(s) involved in the grievance, appeal or fair hearing need this form to be able speak with your designee on your behalf.
- If you need help with this form, you can contact the KanCare Ombudsman's office (855-643-8180). Return this this form to your MCO (if appropriate, see page 2) and the Office of Administrative Hearings. Who to send the form to and the addresses are listed on the second page.

I, _____
(Printed Name of Member)

want the following person _____

to act for me in my: **Grievance, Appeal or Fair Hearing**.
(circle one)

I have talked to this person and he/she agrees to represent me in the process. I understand that personal medical information related to my grievance, appeal or fair hearing may be disclosed to my representative.

1.Name of Representative (Please Print)

_____

2. Address of Representative:

_____

Street Address or PO Box

_____Apt #: _____

City _____ State _____

Zip Code _____

Daytime Phone Number: _____

Evening Phone Number: _____

1. Brief description of the appeal for which this Representative will be acting on my behalf:

   _____

   _____

   _____

2. Signature of Member (or parent/ guardian) *

   _____

   Date: _____

*Relationship to Member: __ Parent __Guardian __ POA

__ Other (explain) _____

Where to send this designation form

- For a grievance: send this form along with your written grievance to whichever organization you are filing the grievance with. If you do a verbal grievance, send just this form to whichever organization you filed the grievance with.
- For an appeal: send this form along with your written appeal to your managed care organization. If you do a verbal notice of your appeal, send just this form to your MCO.
- For a fair hearing: send this form to the Office of Administrative Hearings. If you do a verbal notice of your fair hearing, send just this form to whichever organization you gave verbal notice of the fair hearing with and the Office of Administrative Hearings.

Contact information for grievances, appeals and fair hearings:

Organizations:

- **Amerigroup** (grievances, appeals)
  - Mail to:
  - Administrative Review and Grievance Department/Amerigroup Kansas, Inc.
    9225 Indian Creek
    Parkway, Building #32
    Overland Park, KS 66210
- **Sunflower** (grievances, appeals)
  - Mail or fax to:
    Sunflower Health Plan
    Quality Department 8325
    Lenexa Dr., Suite 200
    Lenexa, KS 66214
    Fax: 1-888-453-4755

- **United Healthcare** (grievances, appeals)
  - Mail to:
    United Healthcare Grievance and Appeals
    P.O. Box 31364
    Salt Lake City, UT 84131-0364
- **KanCare Clearinghouse** (grievances)
  - Mail or fax to:
    KanCare Clearinghouse
    PO Box 3599
    Topeka, KS 66601
    Fax: 1-800-495-1255
- **State fair hearing**; (fair hearings)
  - Mail or fax to:
    Office of Administrative Hearings
    1020 S. Kansas Ave.
    Topeka, Kansas 66612
    Fax: 785-296-4848