

Health First Health Plans



APPOINTMENT OF REPRESENTATION

Member Name: _____ **Plan ID Number:** _____

Named Representative: _____
(please print)

I swear that I am either the member named above, or their legal representative (attach documentation). With my signature below, I permit my "Named Representative" to perform the following activities for me until I specifically request otherwise:

Activity (Check all that apply):	Special instructions:	Effective Date:
<input type="checkbox"/> Filing a Grievance or Appeal		
<input type="checkbox"/> Making enrollment elections		
<input type="checkbox"/> Choosing my providers		
<input type="checkbox"/> Accessing my enrollment information		
<input type="checkbox"/> Accessing my financial information		
<input type="checkbox"/> Accessing my claims and authorizations		
<input type="checkbox"/> Accessing my medical information		
<input type="checkbox"/> Other (please specify):		
<input type="checkbox"/> ALL OF THE ABOVE		

Member Signature: _____ **Date:** _____

Representative Signature: _____ **Date:** _____

Please return the completed form to:

Health First Health Plans, Inc.

Attn: Enrollment
6450 US Highway 1
Rockledge, FL 32955

If you have any questions or concerns, please contact our Customer Service Department any day of the week from 8 a.m. to 8 p.m. at 321.434.5665 or 800.716.7737. If you are hearing impaired, you can also contact us through the Florida TDD Relay Center at 800.955.8771 during the same hours.