UNICARE®

An Anthem Company

MEMBER APPEAL REPRESENTATIVE FORM

Member name: _____

Member ID #: _____

Date of birth: _____

Member address:

_____

City, State, ZIP:

_____

I choose the following person to act on my behalf and represent me in my appeal process with UniCare Health Plan of West Virginia, Inc.:

_____

(Name of representative)

Member signature:

_____

Date: _____

Please send to:

Attn: Grievance and Appeals Department
UniCare Health Plan of West Virginia, Inc.
PO Box 91 Charleston, WV 25321

Or you may fax this form to the Appeals Department at **1-844-882-3520**.

If you fax this form, you also must mail the one you filled out to the Appeals Department at the address listed above.

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Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 800-782-0095 (TTY 711).

UniCare Health Plan of West Virginia, Inc.