Assign an Appeals Representative Form

This form gives permission for another person to file an appeal or grievance on your behalf.

Member information (please print information clearly)			
Member name			
Your WellSense member ID number		Date of birth	
Address	City	State	Zip code
Phone			

I hereby authorize the following person to act as my Appeal Representative for the above referenced Grievance or Internal Appeal. I understand that this person may be given health or payment information related to the above referenced Grievance or Internal Appeal. WellSense Health Plan will act on this information until I revoke or amend this authorization in writing. This authorization expires on the date WellSense sends out the Final Grievance or Internal Appeal decision notice related to this matter.

Appeal representative information (please print information clearly)	
Appeal representative name	Appeal representative phone

Member/Legal Representative Signature: _____

Date: _____

Send completed form to:

WellSense Health Plan
100 City Square, Suite 200
Charlestown, MA 02129

Last Updated 5/24/2024