DESIGNATED CLIENT REPRESENTATIVE FORM

This form must be filled out completely to be valid.

Member name: Member ID:

I authorize the individual listed below to act as my Designated Client Representative (DCR) to address any appeals or grievances on my behalf:

Name Phone number Fax number

Organization (if applicable) City State ZIP code

The permission given on this form will expire at the conclusion of the appeal or grievance, or at any time upon your written request to Colorado Access at the address below.

I understand that my Designated Client Representative will have access to information about me, for the purposes of an appeal or grievance, that includes Protected Health Information (PHI).

Authorization Statements

I am voluntarily signing this form. I understand that I may refuse to sign this form.

I understand that if I give Colorado Access permission to share my information to the Designated Client Representative, the Designated Client Representative may not be required to protect my information.

Parent or legal guardian may sign on behalf of a minor child. Legal guardian, party with power of attorney, or equivalent may sign on behalf of an adult.

Signature of the member (or personal representative - if applicable) Date

Signature of the Designated Client Representative Date

Description of personal representative's authority

Colorado Access
11100 East Bethany Drive, Aurora, CO 80014
Email: clinicalappeals@coaccess.com OR privacy@coaccess.com

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.