PharmaForce™ PBM

Patient's Authorized Representative Form

You have the right to choose someone to act for you during your grievance/appeal. If you wish to have someone act on your behalf, fill out this form and send it to the address or fax number listed below. You can cancel this form by sending a request in writing. If you wish to have someone act for you and we do not get this form from you, your grievance/appeal may be closed.

Patient Information

Patient Name_____ Date of Birth_____

Patient ID Number_____

Authorized Representative

I give permission for _____ to act on my behalf and receive information about my grievance/appeal.

Address of the person acting on my behalf:

_____

Phone:_____ Fax *(if prescriber)*: _____

Relationship: ☐ Parent ☐ Guardian ☐ Conservator ☐ Other: _____

Patient Signature

By signing this form, PharmaForce PBM can release information to the person listed above about this grievance/appeal.

To cancel your grievance/appeal, you can send a letter to:

PharmaForce
Attn: Grievance & Appeals Coordinator
PO Box 613
Columbia, SC 29202
Fax: 866-779-0781

I have read this form and agree to the terms.

_____
Printed Name of Patient

_____ _____
Signature of Patient/Legal Guardian Date