Provider Designation Form
Appeals/Grievances/Complaints

I designate my provider, _____ ,

to act on my behalf regarding the following issue:

Member Name (Print)	Member ID Number
Member Name (Signature)	Date
Provider Name (Print)	
Provider Name (Signature)	Date

Please return completed form to:

CDPHP Appeals and Complaints Department
6 Wellness Way
Latham, NY 12110
Appeals fax #: (518) 641-3401

Complete this form only after services are denied. This is not valid for CDPHP Medicare members. CDPHP Medicare members must use the CMS 1696 Appointment of Representative form available on www.cdphp.com.