

Aetna Better Health® of Kansas
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210



Authorization Release for Appeal/Grievance

An Authorized Representative is a person you choose to act for you during an appeal of services you have been denied or when you file a grievance.

My appeal or grievance is about: _____

Dates of denied services or grievance incident: _____

Person I want to be my Representative: _____

How do you know the person who will be your Representative? (Relative, friend, attorney, etc.)

Address of my Representative: _____

Telephone Number of my Representative: _____

I understand that:

- I can change my mind, at any time. If I change my mind, I'll let you know in writing.
- If I change my mind, it won't change anything you did before I changed my mind.
- When the appeal is over, this agreement will end.
- I know that you may need to give my health information to my representative, so that he/she can act for me.

By signing below, I agree that I have read and understand the information above.

Member Name: _____ (Print) Date: ____ / ____ / ____

Aetna Better Health of Kansas ID#: _____

Member Signature (signature of parent/legal guardian):

If the member isn't signing, what is the signer's relationship to the member?

You can mail or fax the completed form to:

Aetna Better Health® of Kansas
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
Fax: 1- 833-857-7050