Healthy Blue

Reconsideration and Appeal Representative Form

You may have someone else act for you in a Reconsideration or Appeal. We cannot speak with anyone on your behalf in a Reconsideration or Appeal until we receive this form. The person you list below will be accepted as your representative.

Return this form to us by fax, email or mail.

By fax: 1-888-873-7038

By email: LA1appeals@healthybluela.com

By mail: Healthy Blue
ATTN: Appeals Department
3850 N. Causeway Blvd., Ste. 600
Metairie, LA 70002

I, _____, want the following person to act on my behalf in my Reconsideration or Appeal. I understand personal health information related to my care may be given to my representative.

Representative's name: _____

Representative's phone: _____

Representative's address: _____

Representative's relationship to member: _____

If your representative is a health care provider, list your provider's specialty:

_____

Reference # and brief description of the reconsideration or appeal: _____

_____

_____

Representative's signature: _____ Date: _____

Member's signature: _____ Date: _____

If you have questions or need help completing this form, call Member Services at 1-844-521-6941 (TTY 711) Monday through Friday 7 a.m. to 7 p.m.