



# Medicare Part D APPOINTMENT OF REPRESENTATIVE FORM

NAME OF MEMBER

IDENTIFICATION NUMBER

**Part I:**

**To be completed by the member:**

I appoint this individual: \_\_\_\_\_ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF MEMBER		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

**Part II: To be completed by the representative:**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an \_\_\_\_\_  
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

**Mail Form to:**

Medicare Part D Appeals/Grievance Coordinator  
P.O. Box 9201  
N. Quincy, MA 02171-9201

**Fax Form to:**

617-246-8506  
Attention:  
Medicare Part D Appeals/Grievance Coordinator