Appointment of representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical or dental information. **All fields in Sections 1 and 2 are required unless marked optional.**

Section 1: Information about the person appointing the representative - This section must be completed by the member, provider, or other person appointing a representative.

Name	Liberty member ID or National Provider Identifier	
Mailing address	Phone number (with area code)	
City	State Select state	Zip code
Email (optional)	Fax number (optional)	
Signature		Date signed (mm/dd/yyyy)

Section 2: Information about the representative – This section must be completed by the representative.

Representative name		
Professional status or relationship to the person in Section 1 (attorney, relative, etc.)		
Mailing address	Phone number (with area code)	
City	State Select state	Zip code
Email (optional)	Fax number (optional)	
By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.		
Signature		Date signed (mm/dd/yyyy)

Please send the completed form to Liberty Dental Plan by one of the options below.

Postal mail: Liberty Dental Plan, Attn: Eligibility Dept., 1730 Flight Way, Suite 125, Tustin, CA 92782

Email: eligibility@libertydentalplan.com **Fax:** 888-704-9930