Aetna Better Health® of Michigan
2 Towne Square
Suite #275
Southfield, MI 48076

AETNA BETTER HEALTH® OF MICHIGAN

Authorized representative form

Member name _____ Address _____
Member ID# _____ City/State/Zip _____
Member phone _____ Date of birth _____

I am giving the person listed below permission to act as my authorized representative. The person below has my permission to send in an appeal for me.

Name _____
Address _____
City/State/Zip _____
Phone _____

I understand that this form can be canceled or changed by:

- Sending a signed letter to Aetna Better Health of Michigan
- My insurance coverage ending

Canceling this authorization will not change any action Aetna Better Health did before receiving my cancellation.

Send cancel or change letters to:
Aetna Better Health of MI
Attn: Appeals Coordinator
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

By signing below, I am saying that I have read this form and understand it.
If you have questions about this letter, call 866-316-3784.

_____ _____
Member Signature Date