Medicaid Appointment of Representative

MEMBER INFORMATION

Member Name ________________________________
Member ID # _______________ **Birth Date** ___________ **Phone #** ____________
Street Address ____
City ___________________ **State** ___________ **Zip Code** ________

REPRESENTATIVE INFORMATION

Representative Name _________________________ **Phone #** _________________
Street Address ____
City ___________________ **State** ___________ **Zip Code** ________

Appointment of Representative

I appoint this individual _____________________________________ to act as my representative. I authorize this individual to make any request and obtain appeals information. I understand that personal medical information may be disclosed to the representative indicated.

Member Signature: __________________________________ **Date:** _____________

Acceptance of Appointment

I _____________________________ accept the above appointment.

Representative Signature: ____________________________ **Date:** _____________