DESIGNATION FOR AUTHORIZED REPRESENTATIVE FOR SELECTION OF MANAGED CARE PLAN

Recipient Information

Last: _____ **First:** _____ **Middle Initial:** _____

Recipient Medicaid ID: _____ **Recipient Date of Birth:** _____

I wish to designate the person below as my authorized representative for the purpose of selecting my managed care plan with the Agency. I understand some of my protected health information could be discussed in this selection process.

I fully understand that this designation of authorized representation will only permit my Representative to make the health care decision to select my managed care plan.

I also understand that by signing and submitting this form, any previously submitted designated authorized representative form will no longer be valid and cannot be used to select a managed care plan.

Designation will expire in one year or on this date: _____

Representative: _____
(Print Name)

Address: _____

_____

_____

Phone: _____

Government Issued ID Number: _____
(Examples: Driver's License, Passport, Green Card etc…)

Last 5 digits of Social Security #: _____

Providing the Social Security Number is not required. If provided, the Agency will use this information to confirm the identity. Authority given by 42 CFR 435.910.

Recipient: Witness:

(Print Name) (Print Name)

(Signature) (Signature)

Date: Date:

Relationship to recipient:

Form Instructions

Recipient Information:

Last: Enter the legal last name of the recipient.

First: Enter the legal first name of the recipient.

Middle Initial: Enter the first letter of the legal middle name of the recipient.

Recipient Medicaid ID: Enter the Medicaid ID of the recipient.

Recipient Date of Birth: Enter the date of birth for the recipient.

Representative Information:

Representative: Enter the legal name of the representative.

Address: Enter the mailing address of the representative.

Government Issued ID Number: Enter the Government Issued ID of the representative.

(If the representative does not have a Government Issued ID, then they should move to the next step.)

Last 5 Digits of Social Security#: Enter the last 5 digits of the representatives Social Security Number.

Final Instructions:

The form must be signed and dated by the recipient and a witness and submitted using one of the methods below.

Email	Fax	Mail
flenrollmentrequest@automated-health.com	(850) 402-4678	Agency for Health Care Administration P.O. Box 5197 Tallahassee, FL 32314

I understand: I have the right to cancel this authorization by writing to the Agency. Any information previously disclosed would not be subject to my canceling the request. The information discussed during plan selection could be disclosed by the person I am authorizing and no longer protected. I do not have to sign this authorization. If I do not sign, my ability to obtain treatment, payment for health care services or eligibility for benefits will not be affected.