Appointment of Representative Form

Member Name		
Address		
City	**State**	**Zip**
Telephone		
Medicaid Number		

Appointment of Representative:

I ____(print name),

appoint this individual ____(print name)

to act as my representative for purposes of an appeal or grievance for _______________________

____

(specific issue).

I authorize this individual to make any request for information about me relevant to my appeal or grievance; to present or to elicit evidence; to obtain appeals or grievance information; and to receive any notice in connection with my appeal or grievance, wholly in my stead. I understand that my personal medical information may be disclosed to the representative indicated below. I understand that I may revoke my authorization for continuation of this representation at any time by notifying *i*Care in writing. I am aware that my cancellation will not be effective for uses and/or disclosures of my health information that have already been made in reference to this authorization. I understand that the Authorized Representative may withdraw from this representation through written notification to me.

Member Signature: ____ Date _________________

Authorized Representative Name		
Address		
City	**State**	**Zip**
Telephone		

Acceptance of Appointment:

I, ____, hereby accept the appointment as personal representative for the named party seeking representation for the specific appeal or grievance identified above.

Signature of Authorized Representative____**Date**_______________