Appointment of Authorized Representative – Authorized Representative Form Directions

PLEASE READ CAREFULLY

You can give a trusted person or an organization permission to talk about your healthcare with us, see your information and act for you on matters related to your healthcare including the right to make decisions about how your protected health information (PHI) is used and shared. This person can also act for you on other matters, including reviews, appeals and managed care processes. This person is called an "Authorized Representative".

If you need help completing this form, please contact Member Services at 1-866-433-6041 (TTY: 711).

DIRECTIONS

1. **Complete Section I with the required Member Name, Medicaid ID Number and Date fields.**
2. **Complete Section II to indicate if you would like to add, change or remove your Authorized Representative.**
3. **Complete Section III with information about the Authorized Representative.**
4. **Complete Section IV with required Member or Parent/Guardian Signature and Date.**
5. **This form is invalid if the Date, Member Name, Medicaid ID and any required fields of Section III are left blank.***
6. **Mail the completed form to:**

Absolute Total Care
100 Center Point Circle, Suite 100
Columbia, SC 29210

***This form does not need to be completed on behalf of the member if you are the member's legal or personal representative (Guardian, Power of Attorney or Health Care Power of Attorney). However, you must send copies of relevant forms such as Power of Attorney or Order of Guardianship to Absolute Total Care in order to act on behalf of the member. This includes if you are the parent or legal guardian of the minor member, an attorney that has been retained to represent the member or an agent of the member.**

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Appointment of Authorized Representative Form

SECTION I: MEMBER INFORMATION

Member Name (required)	Medicaid ID Number (required)
Date (mm/dd/yyyy) / /	

SECTION II: WHAT DO YOU WANT TO DO?

- ☐ ADD Authorized Representative
- ☐ CHANGE my Authorized Representative
- ☐ REMOVE this person or organization as my Authorized Representative

SECTION III: INFORMATION ABOUT THE AUTHORIZED REPRESENTATIVE

Printed Name of Authorized Representative (First, Middle and Last Name) (*required)*		
Relationship to Member (*not valid if left blank)*		
Authorized Representative's Address		Apartment or Suite #
City	State	Zip Code
Authorized Representative's Phone Number	Authorized Representative's Email, Fax or Alternate Phone Number	
Organization Name (if applicable) *	Dept or Unit # (if applicable) *	ID Number (if applicable) *

Note: It is best to identify a specific unit for large organizations.

SECTION IV: SIGNATURE AND DATE *(form not valid unless signed and dated)*

Member's or Parent/Guardian's Signature	Date (mm/dd/yyyy) / /
Printed Name of Person Signing Form *(not valid left blank)*	Relationship to Member *(not valid left blank)*