



## AUTHORIZED REPRESENTATIVE FORM

.....

<b>Member First Name:</b>	<b>MI:</b>	<b>Last Name:</b>	
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Email:</b>	<b>Home Phone #:</b>	<b>Cell Phone #:</b>	
<b>Member ID#:</b>		<b>Date of Birth (MM/DD/YYYY):</b>	
<p><b>This form is to:</b></p> <p><input type="checkbox"/> Appoint a representative to act on my behalf (able to make changes)</p> <p><input type="checkbox"/> Allow a representative to have access to my information (access only, cannot make changes)</p> <p><input type="checkbox"/> Revoke an existing appointment of representative</p>			
<b>1<sup>st</sup> Representative First Name:</b>	<b>MI:</b>	<b>Last Name:</b>	
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Email:</b>	<b>Home Phone #:</b>	<b>Cell Phone #:</b>	
<b>Relationship to Member:</b>			
<p><b>This appointment is for:</b></p> <p><input type="checkbox"/> For all purposes related to my membership in my health plan benefits.</p> <p><b>Only for (check all that apply):</b></p> <p><input type="checkbox"/> Medical (example: care management, authorizations, transportation)</p> <p><input type="checkbox"/> Enrollment (example: eligibility)</p> <p><input type="checkbox"/> Premium/Financial (example: monthly payments, Explanation of Benefits)</p> <p><input type="checkbox"/> Claims (example: billing)</p> <p><input type="checkbox"/> Grievance/Appeal (e.g. file a complaint or appeal)</p> <p><input type="checkbox"/> Sensitive Services (e.g. HIV/AIDs, pregnancy, sexually transmitted diseases)</p>			

**This authorization is effective:**

From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Until I am no longer enrolled with plan.

**\*Note:** For Medicare Plus DSNP, the appointment for Grievance/Appeal is only effective for 1 year from the date signed.

**This form is to:**

Appoint a representative to act on my behalf (able to make changes)

Allow a representative to have access to my information (access only, cannot make changes)

Revoke an existing appointment of representative

**2<sup>nd</sup> Representative First Name:**

**MI:**

**Last Name:**

**Street Address:**

**City:**

**State:**

**Zip Code:**

**Email:**

**Home Phone #:**

**Cell Phone #:**

**Relationship to Member:**

**This appointment is for:**

For all purposes related to my membership in my health plan benefits.

**Only for (check all that apply):**

Medical (example: care management, authorizations, transportation)

Enrollment (example: eligibility)

Premium/Financial (example: monthly payments, Explanation of Benefits)

Claims (example: billing)

Grievance/Appeal (example: file a complaint or appeal)

Sensitive Services (example: HIV/AIDs, pregnancy, sexually transmitted diseases)

**This authorization is effective:**

From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Until I am no longer enrolled with plan.

**\*Note:** For Medicare Plus DSNP, the appointment for Grievance/Appeal is only effective for 1 year from the date signed.

**Member's Identifying documentation attached (A photocopy of one of the following):**

Valid U.S Driver's License    Valid DMV Identification Card    Birth Certificate

Passport/ID Card    Government Issued Photo ID Card

Other \_\_\_\_\_

**If no identification is attached, signature must be notarized.**

**Please place stamp here. Not official unless stamped by a notary Public.  
\*Notary services are not provided or covered by L.A. Care, fees may apply\***

\_\_\_\_\_  
**Notarized by**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date (MM/DD/YYYY)**

**If someone other than the member is completing this form, complete this section with your information and sign on behalf of the member on the last page. You are the:**

- Parent of a Minor  
 Guardian  
 Conservator  
 Administrator of Estate  
 Executor of will  
 Other \_\_\_\_\_

**A copy of the Legal documentation to verify that you are the Parent, Conservator, Guardian, Executor of a Decedent's Will, or Have Medical Decision-Making Authority for the member must be attached.**

<b>Member First Name:</b>	<b>MI:</b>	<b>Last Name:</b>	
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Email:</b>	<b>Home Phone #:</b>	<b>Cell Phone #:</b>	
<b>Relationship to Member:</b>			

**This Authorization allows the named representative to (as selected on this form):**

- discuss your information, health care benefits, care and treatment, and claims with L.A. Care on your behalf.
- submit requests or changes about your health plan, physicians, and medical group on your behalf;
- file a grievance with L.A. Care on your behalf. For L.A. Care Medicare Plus DSNP, this form is limited to one year from the date it is signed.
- obtain your Personal Health Information (PHI) from L.A. Care. This may include health information like substance abuse, mental health, behavioral health, genetic testing and HIV/AIDS status. Once released, the information may no longer be protected by privacy laws and may be further disclosed by the representative without your authorization.

**Members must have:**

- reviewed and completed the form before signing.
- provided all information required by L.A. Care.
- understand that L.A. Care and the State of CA Department of Health Care Services are not responsible for the authorized representative's actions, or what they do with the information they receive.
- understand that the revocation will not affect any action taken, or any information already released, based upon this Authorization before the request to revoke has been processed by L.A. Care.

**Members have the right to:**

- appoint any person above the age of 18 as the authorized representative.
- update or revoke this authorization at any time with a written request to L.A. Care.
- request a copy of this form and information used or shared by this authorization.

**Restrictions:**

- This authorization is recognized for one year from the date signed unless revoked earlier in writing.
- If changes are made to the form, the member will need to reauthorize/re-notarize the form.
- This authorization automatically ends 120 days after the member is no longer enrolled with L.A. Care.

I understand that my treatment, payment, enrollment, or eligibility for benefits are not affected by whether or not I sign this form.

_____ Today's Date	_____ Member's Printed Name	_____ Member's Signature
_____ Today's Date	_____ Appointed Representative #1	_____ Signature
_____ Today's Date	_____ Appointed Representative #2	_____ Signature

**Return form to:**

L.A. Care Health Plan,  
CSC – Authorized Rep Form  
1200 West 7<sup>th</sup> Street  
Los Angeles, CA 90017

**Toll-free FAX: 1.844.657.7272** - This is a secure fax number. You may include a cover sheet marked "Confidential".  
Please use caution when faxing Protected Health Information (PHI).

To download a copy of this form please visit [lacare.org](http://lacare.org). For questions regarding this form or how to submit this form, please contact Member Services at **1.888.839.9909** (TTY 711). We are available 24 hours a day, 7 days a week. This call is free.

You can get this form for free in Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Spanish, Tagalog, Vietnamese or other formats, such as large print, braille, or audio. Call **1.833.522.3767**. TTY/TDD users should call **711**. We are open 24 hours a day, 7 days a week. The call is free.