Return form to:
L.A. Care Health Plan
CSC – Authorized Rep Form
1200 West 7th Street
Los Angeles, CA 90017

AUTHORIZED REPRESENTATIVE FORM

Member First Name:	MI:	Last Name:	
Street Address:	City:	State:	Zip Code:
Email:	Home Phone #:	Cell Phone #:	
Member ID#:		Date of Birth (MM/DD/YYYY):	

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)

1st Representative First Name:	MI:	Last Name:		
Street Address:	City:		State:	Zip Code:
Email:	Home Phone #:		Cell Phone #:	
Relationship to Member:			Date of Birth (MM/DD/YYYY):	

This appointment is for:
☐ For all purposes related to my membership in my health plan benefits.

Only for (*check all that apply*)**:**
☐ Medical (*e.g. care management, authorizations, transportation*)
☐ Enrollment (*e.g. eligibility*)
☐ Premium/Financial (*e.g. monthly payments, Explanation of Benefits*)
☐ Claims (*e.g. billing*)
☐ Grievance/Appeal (*e.g. file a complaint or appeal*)
☐ Sensitive Services (*e.g. 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.

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)

2nd Representative First Name:	MI:	Last Name:	
Street Address:	**City:**	**State:**	**Zip Code:**
Email:	**Home Phone #:**	**Cell Phone #:**	
Relationship to Member:		**Date of Birth (MM/DD/YYYY):**	

This appointment is for:

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

Only for (*check all that apply*):

☐ Medical (*e.g. care management, authorizations, transportation*)

☐ Enrollment (*e.g. eligibility*)

☐ Premium/Financial (*e.g. monthly payments, Explanation of Benefits*)

☐ Claims (*e.g. billing*)

☐ Grievance/Appeal (*e.g. file a complaint or appeal*)

☐ Sensitive Services (*e.g. 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.			
First Name:	**MI:**	**Last Name:**	
Street Address:	**City:**	**State:**	**Zip Code:**
Email:	**Home Phone #:**	**Cell Phone #:**	
Relationship to Member:		**Date of Birth (MM/DD/YYYY):**	

A copy Legal documentation to verify that you are one of the following must be submitted:

☐ Parent of a Minor ☐ Guardian ☐ Conservator ☐ Power of Attorney

☐ Other ____

A copy of your identifying documentation must also be submitted:

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

☐ Passport/ID Card ☐ Government Issued Photo ID Card

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.

You must:

- review and complete 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 on this Authorization before the request to revoke has been processed by L.A. Care.

You 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**

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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 www.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.