AUTHORIZED REPRESENTATIVE DESIGNATION FORM

New York Medicaid Choice
1-800-505-5678 (TTY users: 1-888-329-1541)

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Complete and sign this form to name a person as your Authorized Representative with New York Medicaid Choice. You can submit the completed form by fax to (917) 228-8601 or by mail to New York Medicaid Choice, PO Box 5009, New York, NY 10274.

SECTION 1: PERSON DESIGNATING A REPRESENTIVE. *Please print*

Individual's Name: (First name, Last name) _____

Medicaid ID: ___ ___ ___ ___ ___ ___ ___ ___ SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: _____ City: _____

State: _____ Zip code: _____ Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___

Phone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Cell # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

SECTION 2: AUTHORIZED REPRESENTATIVE. *Please print*

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

Representative's language preference for written materials:
☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Haitian Creole ☐ Korean ☐ Italian

Representative's Signature: _____

* If the signature is of the legal representative, describe the authority to act in that capacity (e.g., guardianship, committee for an incompetent, power of attorney, health care proxy, etc.), in the space below, or if necessary, attach additional pages.

_____

SECTION 3: SIGNATURE

- By signing below I give New York Medicaid Choice permission to release information, in connection with managed care enrollment/disenrollment decisions to the person named in **Section 2** as checked below:
  Please check all that apply. ☐ Medicaid ☐ Medicaid-Medicare ☐ Protected Health/Information
- I would like my mail from New York Medicaid Choice to be sent to:
  ☐ Me only ☐ Me and my Representative ☐ My Representative only
- The time period during which release of information is authorized is:
  From: ___ ___ / ___ ___ / ___ ___ ___ ___ to: ___ ___ / ___ ___ / ___ ___ ___ ___
- I understand that this approval is voluntary. I may withdraw this approval at any time before the "To Date" noted above, by advising New York Medicaid Choice in writing or calling **1-800-505-5678.** Withdrawing consent given to a legal representative will be verified.

I understand that if the person approved to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I also understand that the Authorized Representative Designation Form is used in connection with managed care options.

Individual's Signature: _____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___