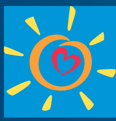

AUTHORIZED REPRESENTATIVE FORM

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):	

I am signing the form to:
☐ Appoint a representative ☐ Revoke an existing appointment of representative

I am the:
☐ Member ☐ Parent of a Minor ☐ Guardian ☐ Conservator ☐ Administrator of Estate
☐ Executor of will ☐ Other ____

My information is:

Member First Name:	MI:	Last Name:	
Street Address:	City:	State:	Zip Code:
Email:	Home Phone #:	Cell Phone #:	

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

Only for (*check all that apply*): ☐ Enrollment ☐ Premium/Financial ☐ Claims ☐ Grievance/Appeal
☐ Other: ____

This authorization is effective immediately and will remain in effect until:

☐ Earlier of 1 year from _____/_____/__________ , or 120 days after I am no longer enrolled.
☐ Specific dates from _____/_____/__________ to _____/_____/__________.

1st Representative First Name:	MI:	Last Name:	
Street Address:	City:	State:	Zip Code:
Email:	Home Phone #:	Cell Phone #:	
Relationship to Member:			
2nd Representative First Name:	MI:	Last Name:	
Street Address:	City:	State:	Zip Code:
Email:	Home Phone #:	Cell Phone #:	
Relationship to Member:			

Identifying documentation attached *(You must provide 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 ____

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 Individual must be attached.

If no identification is provided, 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, additional fees may apply

____ Notarized by

_______/_____/___________ Date (MM/DD/YYYY)

This Authorization allows the named representative to:

- 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.
- 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:

- 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	**Printed Name** *(If other than Member)*	**Signature** *(If other than Member)*

Return form to: L.A. Care Health Plan, Customer Solution Center, 1200 West 7th Street, Los Angeles, CA 90017

Toll-free FAX: 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.