AUTHORIZATION – Medicaid Managed Care Requests

I authorize the following individuals or organizations to represent me in making requests regarding my Medicaid managed care or Managed Long Term Care Services. They may, on my behalf make requests including but not limited to:

1. Request an Internal Appeal of an adverse determination by my plan;
2. Request a Fair Hearing of an adverse determination by my plan;
3. Request prior approval of a new service or of additional hours or amounts of a service that I receive ("concurrent review").
4. File a grievance with my plan.
5. File a complaint with the NYS Department of Health.

This authorization applies to my current plan, which is (NAME) _____ _____and also to any different plan I might enroll in at a later date.

Authorized Individuals or Organizations (fill in and check one or more):

- ☐ NAME _____ Relationship _____
  - Address _____
  - Cell phone _____ E-mail _____
  - ☐ I want this person to act for me for all steps of the appeal or fair hearing or authorize them to appoint a representative to act for me.
- ☐ ORGANIZATION NAME _____
  - Relationship (CIRCLE: senior center, case management agency, clinic, attorney, geriatric care manager) OTHER: _____
  - Contact person: _____
  - Address _____
  - Phone _____ E-mail _____
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing or authorize it to appoint a representative to act for me.
- ☐ **Independent Consumer Advocacy Network (ICAN)** - including all participating organizations in the network. Main tel 844-614-8800
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing

Signed _____ NAME (print): _____

Date of birth _____ Medicaid or Plan ID _____

Address _____ Tel _____

DATE: _____