Medicaid appointment of representative request form

If you want someone to act for you regarding a complaint or appeal, you can request to make that person an authorized representative.

How long is authorized representative status valid for?

Authorized representative status is valid only for the specific form submission. A new authorization is required each time an appeal is submitted.

If you are under the age of 18, a parent or legal guardian is automatically appointed as your authorized representative.

For matters involving substance abuse or behavioral health treatment, a parent or legal guardian is automatically appointed as your authorized representative if you are under the age of 14.

What must be done to request for someone to become an authorized representative?

To request that someone becomes an authorized representative, you **must** complete, sign and submit this form.

Where do I send the completed form?

Return the completed form to Priority Health by:

Mail
Priority Health
Attn: Grievance & Appeals Department
1231 East Beltline NE, MS 1145
Grand Rapids, MI 49525

Fax
616.975.8850

Email
phmemberappeals@priorityhealth.com

What if I have questions?

Contact Customer Care at 888.975.8102 (TTY: 711). We're available Monday through Thursday from 7:30 a.m. – 7 p.m., Friday from 9 a.m. – 5 p.m. and Saturday from 8:30 a.m. – noon ET. You can also log in to your member account at ***priorityhealth.com*** to send a message.

1. Member information

First name	Last name	M.I.
Date of birth _____/_____/_____	Priority Health ID number	

Street address		Unit/apt./lot no.
City	State	Zip Code
Email		Phone ( ) -

2. Authorized representative information

First name	Last name

What is your relationship to the member? *(choose one)*

☐ Conservator ☐ Dependent ☐ Healthcare provider ☐ Legal guardian ☐ Parent
☐ Power of attorney ☐ Spouse ☐ Other: _____

If 'Healthcare provider', provide your National Provider Identifier (NPI):
_____

Street address		Unit/apt./lot no.
City	State	Zip Code
Email		Phone ( ) -
Authorized representative signature		Today's date _____/_____/_____

3. Services information

What should the authorized representative act on your behalf for? *(mark all that apply)*

☐ Appeals ☐ Complaints ☐ Requests for equipment and/or supplies ☐ Service

If 'Service', what service(s)? _____

Do you want the authorized representative status to expire sooner than one year from the date the form is signed? ☐ Yes ☐ No

If 'Yes', when should the status end? _____/_____/_____

4. Acknowledgement

I authorize this person to represent me. I understand that my health information may be shared with or by my authorized representative. If those receiving it are not health plans or providers, my information may no longer be protected by federal privacy laws. This may include medical, pharmacy, dental, vision, mental health, substance abuse, human immunodeficiency virus (HIV) infections, acquired immunodeficiency syndrome (AIDS), psychotherapy, reproductive, communicable disease, and health care program details, along with details on services and requests for equipment or supplies. If I don't sign this form, I can still receive medical help, but my appointed representative's requests won't be processed. This approval lasts one year unless I specify otherwise and can be revoked anytime by notifying Priority Health in writing.

Member signature	Today's date _____/_____/_____