Sc medicaid authorized representative form

1350

STATE OF SOUTH CAROLINA
DEPARTMENT OF REVENUE

POWER OF ATTORNEY AND DECLARATION OF REPRESENTATIVE

SC2848

Part I Power of Attorney

1 Taxpayer information (Note: Taxpayer(s) must sign and date this form on page 2, line 8.)

- Taxpayer name(s) and address **(Type or print.)**
- Social Security number(s)
- Employer identification number
- Plan number, if applicable
- Daytime telephone number ( )
- Email Address

hereby appoint(s) the following representative(s) as attorney(s) - in fact:

2 Representative(s) (Type or print.)

- Name and address of specific individual
  - Telephone No. ( )
  - Fax No. ( )
  - Check if new: Address ☐ Telephone No. ☐

Name and address of specific individual
- Telephone No. ( )
- Fax No. ( )
- Check if new: Address ☐ Telephone No. ☐

Name and address of specific individual
- Telephone No. ( )
- Fax No. ( )
- Check if new: Address ☐ Telephone No. ☐

to represent the taxpayer(s) before the SC Department of Revenue for the following tax matters:

3 Tax Matters - A general reference to "All years," "All periods," or "All taxes" is **not** acceptable.

Type of Tax (Individual, Corporate, Withholding, Sales, etc.)	Tax Form Number (SC1040, SC1120, ST-3, etc.)	Year(s) or Period(s) (See line 3 instructions)

4 Acts Authorized - A representative is an individual authorized to receive and inspect confidential tax information and to perform any and all acts on behalf of the taxpayer with respect to the tax matters described in line 3, including the authority to sign any agreements, consents or other documents. You may not use a Power of Attorney form to authorize a representative to receive refund checks. You may authorize a representative to sign a return ONLY as set forth in South Carolina Code Section 12-2-75.

List any specific additions to or deletions from the acts otherwise authorized in this power of attorney: ____________

5 Receipt of Refund Checks - If you want to authorize a representative named in line 2 to receive, **BUT NOT TO ENDORSE OR CASH** refund checks, initial here ____________ and list the name of that representative below.

Name of representative to receive refund check(s) ____________

33071028

Authorized Representative Form

Please send completed form back to us at:
UnitedHealthcare
P.O. Box 29150
Hot Springs, AR 71903-9150

This form provides permission for United HealthCare Services, Inc. (UHS), on behalf of itself and related companies, to discuss or give out your personal health information to a person who is your Authorized Representative. Your approval on this form limits the use of your information for that purpose only.

SECTION 1: Enrollee Information

By signing this form, I understand and agree that United HealthCare Services, Inc., on behalf of itself and related companies, may release my personal health information to ______________________ to act as my Authorized Representative.

Enrollee Name	Member ID Number
Address	
Telephone Number	Email Address *(Please send me periodic plan updates.)*

Please Note: This authorization does not allow your "Authorized Representative" to make any of your treatment decisions or direct care decisions. If you want help with your health care and treatment decisions, you must get additional legal documentation. If you have questions, contact your attorney.

Signature	Date

SECTION 2: Authorized Use and/or Disclosure

To be completed by the Authorized Representative:

I, ______________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

Authorized Representative Signature	Date
Name (Please Print)	Telephone Number
Address	
Email Address *(Please send me periodic plan updates.)*	Relationship to You

SECTION 3: Waiver of Fee for Presentation

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue must complete this section.)

I waive my right to charge and collect a fee for representing ______________________ before the Secretary of the Department of Health and Human Services.

Signature	Date

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Authorized Representative Designation/Change Request

Заявитель/получатель

Имя ______________________

Адрес ______________________ (Улица) ________ (Кв.)
______________________ (Город) ________ (Штат) ________ (Почтовый индекс)

Дата ______________________

Номер дела ______________________

Если ранее Вы не назначали уполномоченного представителя для осуществления действий от Вашего имени, но хотели бы сделать это, укажите его имя и адрес.

Имя ______________________

Адрес ______________________ (Улица) ________ (Кв.)
______________________ (Город) ________ (Штат) ________ (Почтовый индекс)

Телефон: (_____) ________ - ____________ ☐ Домашний ☐ Рабочий ☐ Мобильный ☐ Другой

Если ранее Вы назначили уполномоченного представителя, но хотите отказаться от него или назначить нового:

☐ Отказ от ранее назначенного уполномоченного представителя

Имя ______________________

Адрес ______________________ (Улица) ________ (Кв.)
______________________ (Город) ________ (Штат) ________ (Почтовый индекс)

Телефон: (___) ____ - ________ ☐ Домашний ☐ Рабочий ☐ Мобильный ☐ Другой

☐ Назначение нового уполномоченного представителя

Имя ______________________

Адрес ______________________ (Улица) ________ (Кв.)
______________________ (Город) ________ (Штат) ________ (Почтовый индекс)

Телефон: (___) ____ - ________ ☐ Домашний ☐ Рабочий ☐ Мобильный ☐ Другой

Я понимаю, что назначенный мной уполномоченный представитель получит доступ к моей личной медицинской информации. Я разрешаю своему уполномоченному представителю (отметьте все нужные варианты):

- ☐ Подавать заявления об участии и (или) о продлении участия в программе Medicaid от моего имени
- ☐ Обсуждать мое заявление об участии в программе Medicaid или мое дело, если это необходимо
- ☐ Получать уведомления и корреспонденцию

Я понимаю, что данное назначение будет действовать до тех пор, пока я не изменю или не откажусь от него.

______________________ Подпись заявителя/получателя ________ Дата

DOH-5247ru (5/17) Rev. 11/17

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Authorized Representative Designation/Change Request

Applicant/Recipient

Name _____

Address _____ _____ _____
Street Apt# City State Zip

Date _____

Case Number _____

If you have not previously provided an Authorized Representative to act on your behalf and would like to do so, please provide his/her name and address.

Name _____

Address _____ _____ _____
Street Apt# City State Zip

Phone # (____)____–____ ☐home ☐work ☐cell ☐other

If you previously provided an Authorized Representative and would like to discontinue or change to someone new:

☐ Discontinue Current Authorized Representative

Name _____

Address _____ _____ _____
Street Apt# City State Zip

Phone # (____)____–____ ☐home ☐work ☐cell ☐other

☐ Designate New Authorized Representative

Name _____

Address _____ _____ _____
Street Apt# City State Zip

Phone # (____)____–____ ☐home ☐work ☐cell ☐other

I understand my designated Authorized Representative will have access to my personal health information.
I would like my Authorized Representative to (check all that apply):

☐ Apply for and/or renew Medicaid for me
☐ Discuss my Medicaid application or case, if needed
☐ Get notices and correspondence

I understand this designation will remain in effect until I change or discontinue it.

_____ _____
Signature of Applicant/Recipient Date

DOH-5247 (10/17)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

You do not need to sign this form to apply for or receive MO HealthNet benefits. You may contact the Family Support Division to apply for benefits, complete your annual review, or conduct other business on your own; or you may appoint an authorized representative to represent you, as provided by 42 CFR 435.908. To appoint an authorized representative, you must complete this form and the person you appoint to be your authorized representative must acknowledge and accept the appointment. **Notwithstanding the availability of the authorized representative, the Family Support Division may communicate directly with you as the division may determine appropriate.**

I, (PRINT NAME)	TELEPHONE NUMBER

ADDRESS

DCN OR SSN

HEREBY APPOINT

NAME (PRINT NAME)	TELEPHONE NUMBER
ADDRESS	**E-MAIL ADDRESS**

TO ACT AS MY AUTHORIZED REPRESENTATIVE.

THIS INDIVIDUAL/ORGANIZATION IS DESIGNATED AS MY AUTHORIZED REPRESENTATIVE TO RECEIVE CORRESPONDENCE FROM THE FAMILY SUPPORT DIVISION.

☐ YES ☐ NO

THE APPOINTED INDIVIDUAL/ORGANIZATION WILL ACT WITH A RESPONSIBILITY AND OBLIGATION TO ME FOR THE FOLLOWING PURPOSE:

☐ APPLICATION ☐ ANNUAL REVIEW ☐ AGENCY ACTION

The person/organization I have appointed has knowledge of my circumstances necessary to complete an application, annual review or act on my behalf and shall not willfully make a false statement, misrepresentation, conceal information, or fail to report any fact or event required to be reported by any law, regulation or rule of this State or the United States.

I understand that I am responsible for the information provided by my authorized representative, including any information that may be incorrect.

APPLICANT/PARTICIPANT SIGNATURE	DATE

ACKNOWLEDGEMENT AND ACCEPTANCE OF APPOINTMENT OF AUTHORIZED REPRESENTATIVE

I, (PRINT NAME)	TELEPHONE
ADDRESS	

I am age 18 or older (not applicable to organization) and have knowledge of the applicant/participant's circumstances necessary to complete an application, annual review or agency action on their behalf. I (or this organization) shall not willfully make a false statement, misrepresentation, conceal information, or fail to report any fact or event required to be reported by any law, regulation or rule of this State or the United States.

I (or this organization) hereby accept this appointment of authorized representative for the duration and purpose stated above.

AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

MO 886-2817 (8-15) IM-6AR

How to become an authorized representative for medicaid. What is an authorized representative for medicaid.

We hope our members will always be satisfied with Absolute Total Care and our providers. If you are not satisfied, you have the right to file a grievance. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination, such as: Wait time to see a doctor Being treated unfairly by office staff Unclean facilities You have the right to file a grievance. A grievance may be filed at any time. If you need assistance with your grievance please call Absolute Total Care at 1-866-433-6041 (TTY: 711) and we will assist you in filing your grievance. This includes providing assistance with accessing interpreter services and hearing impaired services, if needed, at no cost to you. We cannot and will not treat you differently because you have filed a grievance. Your benefits will not be affected. Who can file a grievance? An Absolute Total Care member or a member's authorized representative. An authorized representative is a person or provider a member gives the right to act on their behalf. The member can give permission for a person or a provider to act on their behalf in writing or by completing the Appointment of Authorized Representative Form found on the Member Handbooks and Forms page. How to file a grievance: Call Member Services at 1-866-433-6041 (TTY: 711). Mail, email, or fax a completed Grievance Form or written letter telling us why you are not satisfied. You can obtain a Grievance Form on the Member Handbooks and Forms page. Be sure to include: Your first and last name Your Absolute Total Care member ID card number Your address and telephone number The reason for your grievance Mail: Absolute Total Care Grievance and Appeals Coordinator 100 Center Point Circle Columbia SC 29210 Fax: 1-866-918-4457 Email: SC_Appeals_And_Grievs@centene.com Present your evidence in person at the address above When will Absolute Total Care tell me the decision about my grievance? Absolute Total Care will send you a letter telling you that we received your grievance within five calendar days. We will try to make a decision right away. Sometimes we can resolve it over the phone. If not, we will give you a written decision within 90 calendar days after we get your grievance. Absolute Total Care may extend the timeframe to resolve the grievance up to 14 calendar days if: You or your authorized representative request an extension, or Absolute Total Care can demonstrate that there is a need for additional information that is in the member's best interest. If an extension is made to your grievance, we will contact you and your provider promptly by phone to let you know of our decision. We will also send you a letter within two calendar days that includes the reason for the extension and your right to file a grievance if you disagree with our decision. All clinically urgent grievances will be reviewed by a medical director and resolved within 72 hours from receipt by Absolute Total Care. If you are not satisfied with the first decision of the grievance, you can request a second review of your grievance within 30 calendar days from the receipt of the notice of the original decision. Absolute Total Care will review your grievance again. The second grievance review will be completed by someone who did not make the decision on the first grievance review. After the first and second review of the grievance have been completed, you do not have the right to file a State Fair Hearing. We&#65533;re sorry&#65533; &#65533;your query looks similar to an automated request from a computer virus or spyware application or you may be trying to access our site from a blocked region. To protect our users, we can&#65533;t process your request. We apologize for the inconvenience. Reference Number: 18.1e85655f.1659416077.21958dca Authorization for Release of Information andAppointment of Authorized Representativefor Medicaid Applications/Reviews and AppealsName of Medicaid applicant/memberAppointing an Authorized RepresentativeWould you like to allow someone to represent you on all matters related to your case?You can give a trusted person or an organization permission to talk about your application with us, see your information, and actfor you on matters related to your application, including getting information about your application and signing your applicationon your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes.This person is called an "authorized representative." The Medicaid eligibility worker can release any information regardingyour application/review and status to your authorized representative. More than one person or organization can serve as yourauthorized representative.You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorizedrepresentative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, youdo not need to complete this section.Full Name of Authorized Representative or OrganizationRemove this person or organizationas my authorized representativePoint of Contact If Authorized Representative Is An OrganizationID number (if applicable)Authorized Representative's phone numberAuthorized Representative's email addressAuthorized Representative's address (Leave blank if you don't have one)Apartment or suite number*It is best to identify a specific unit for large organizations.Permission to Release InformationIs there anyone that you would like us to share information with about your application?By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission torelease information about this application to this additional person or organization.Name of person/organizationID Number (if applicable)Medicaid applicant/member's signatureIf signing with an "X," please have two people sign below as witnesses.Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason:Mail your signed form to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 Fax: (888) 820-1204NEED HELP WITH YOUR APPLICATION?or call us at 1-888-549-0820. Para obtener una copia de este formularioen Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer servicerepresentative the language you need. We'll get you help at no cost to you. TTY users should call 1-888-842-3620.DHHS Form 1282 - Authorized Representative (Oct. 2018) Authorization for Release of Information andAppointment of Authorized Representativefor Medicaid Applications/Reviews and AppealsName of Medicaid applicant/memberAppointing an Authorized RepresentativeWould you like to allow someone to represent you on all matters related to your case?You can give a trusted person or an organization permission to talk about your application with us, see your information, and actfor you on matters related to your application, including getting information about your application and signing your applicationon your behalf. This person can also act for you on other matters, including reviews, appeals and managed care processes.This person is called an "authorized representative." The Medicaid eligibility worker can release any information regardingyour application/review and status to your authorized representative. More than one person or organization can serve as yourauthorized representative.You can appoint, withdraw or change an authorized representative at any time. If you ever need to change your authorizedrepresentative, contact Healthy Connections. If you are a legally appointed representative for someone on this application, youdo not need to complete this section.Full Name of Authorized Representative or OrganizationRemove this person or organizationas my authorized representativePoint of Contact If Authorized Representative Is An OrganizationID number (if applicable)Authorized Representative's phone numberAuthorized Representative's email addressAuthorized Representative's address (Leave blank if you don't have one)Apartment or suite number*It is best to identify a specific unit for large organizations.Permission to Release InformationIs there anyone that you would like us to share information with about your application?By completing this section, you can give permission for the following person to receive information about your application/case, but they won't have the ability to act on your behalf like an authorized representative. You also give SCDHHS permission torelease information about this application to this additional person or organization.Name of person/organizationID Number (if applicable)Medicaid applicant/member's signatureIf signing with an "X," please have two people sign below as witnesses.Member is incapacitated and unable to sign. SCDHHS reserves the right to verify member's inability to sign. Provide reason:Mail your signed form to: SCDHHS - Central Mail, PO Box 100101, Columbia, SC 29202-3101 Fax: (888) 820-1204NEED HELP WITH YOUR APPLICATION?or call us at 1-888-549-0820. Para obtener una copia de este formularioen Español, llame 1-888-549-0820. If you need help in a language other than English, call 1-888-549-0820 and tell the customer servicerepresentative the language you need. We'll get you help at no cost to you. TTY users should call 1-888-842-3620.DHHS Form 1282 - Authorized Representative (Oct. 2018) Providers This is a library of the forms most frequently used by health care professionals. Looking for a form but don't see it here? Please contact your provider representative for assistance. We look forward to working with you to provide quality services to our members.

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