MedStar Family Choice
DISTRICT OF COLUMBIA

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative have the authority to make requests, present evidence, get information, and receive all communication about you and your action.

Section 1*: Information* about the person appointing the representative.

Name of Enrollee (First and Last Name)	Medicaid ID/ Health Card ID	
Residence Address	Phone Number	
City	State	ZIP Code
Email address (optional)		

Section 2: Information about the representative

Authorized Representative (First and Last name)	New ☐ Change ☐ Remove ☐	
Authorized Representative's Address (Street name)	Apartment or Suite Number	
City	State	ZIP Code
Authorized Representative's Phone Number	Email Address	
Organization's Name (if Applicable)		

Section 3: Declaration and Signature

By signing this form that I attest and certify the following;

- ☐ I certify that the individual designated above is allowed to act on my behalf.
- ☐ I understand that my authorized representative may see my personal and confidential information.
- ☐ I understand that anyone knowingly providing false information may be prosecuted under applicable federal and District laws.
- ☐ I understand that I remain liable if my authorized representative provides any false information. If the District determines that an authorized representative has knowingly provided false information, it may disqualify that person from being an authorized representative .
- ☐ I understand that if my authorized representative is a provider or staff or volunteer of an organization, they must affirm that they will adhere to federal regulations relating to confidentiality of information and the prohibition against reassignment of provider claims.
- ☐ I understand that the power to act as an authorized representative is valid until I modify the authorization or notify the agency that the representative is no longer authorized to act on my behalf, *OR* the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based.

Enrollee Signature _____ **Date Signed:** _____