



## DESIGNATION FOR AUTHORIZED REPRESENTATIVE FOR SELECTION OF MANAGED CARE PLAN

### Recipient Information

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle  
Initial: \_\_\_\_\_  
Recipient Medicaid ID: \_\_\_\_\_ Recipient Date of Birth: \_\_\_\_\_

I wish to designate the person below as my authorized representative for the purpose of selecting my managed care plan with the Agency. I understand some of my protected health information could be discussed in this selection process.

I fully understand that this designation of authorized representation will only permit my Representative to make the health care decision to select my managed care plan.

I also understand that by signing and submitting this form, any previously submitted designated authorized representative form will no longer be valid and cannot be used to select a managed care plan.

Designation will expire in one year or on this date: \_\_\_\_\_

Representative: \_\_\_\_\_  
(Print Name)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Government Issued ID Number: \_\_\_\_\_  
(Examples: Driver's License, Passport, Green Card etc...)

Last 5 digits of Social Security #: \_\_\_\_\_

Providing the Social Security Number is not required. If provided, the Agency will use this information to confirm the identity. Authority given by 42 CFR 435.910.

Recipient:

Witness:

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Signature)

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to recipient: \_\_\_\_\_

### **Form Instructions**

#### **Recipient Information:**

**Last:** Enter the legal last name of the recipient.

**First:** Enter the legal first name of the recipient.

**Middle Initial:** Enter the first letter of the legal middle name of the recipient.

**Recipient Medicaid ID:** Enter the Medicaid ID of the recipient.

**Recipient Date of Birth:** Enter the date of birth for the recipient.

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#### **Representative Information:**

**Representative:** Enter the legal name of the representative.

**Address:** Enter the mailing address of the representative.

**Government Issued ID Number:** Enter the Government Issued ID of the representative.

*(If the representative does not have a Government Issued ID, then they should move to the next step.)*

**Last 5 Digits of Social Security#:** Enter the last 5 digits of the representatives Social Security Number.

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#### **Final Instructions:**

The form must be signed and dated by the recipient and a witness and submitted using one of the methods below.

Email	Fax	Mail
<a href="mailto:flenrollmentrequest@automated-health.com">flenrollmentrequest@automated-health.com</a>	(850) 402-4678	Agency for Health Care Administration P.O. Box 5197 Tallahassee, FL 32314

**I understand: I have the right to cancel this authorization** by writing to the Agency. Any information previously disclosed would not be subject to my canceling the request. The information discussed during plan selection could be disclosed by the person I am authorizing and no longer protected. I do not have to sign this authorization. If I do not sign, my ability to obtain treatment, payment for health care services or eligibility for benefits will not be affected.