COUNTYCARE AUTHORIZED REPRESENTATIVE DESIGNATION

To have someone else act on your behalf in an appeal or grievance, complete and return this form. The person listed will be accepted as your authorized representative. We are unable to speak with this person on your behalf unless this form is completed, signed, and returned to us.

CountyCare Health Plan
P.O. Box 21153
Eagan, MN 55121
(Fax) 312-548-9940

1. **I hereby authorize the following person to act on my behalf in the filing and processing of my appeal or grievance with CountyCare:**

_____
Name of Authorized Representative

2. **Brief description of the service and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:**

3. **Address of Authorized Representative**

_____
Street Address or PO Box **Apt#**

_____
City **State** **Zip Code**

( )
_____
Phone Number: *Daytime* **Phone Number:** *Evening*

4. **Member Signature**

_____
Printed Name of Member (or legal representative)* **Date**

_____
Signature of Member (or legal representative)* **Date**

***Relationship if other than the Member:** ☐ **Parent** ☐ **Guardian** ☐ **Conservator** ☐ **Other – Please Specify**

_____

Please note you may revoke this authorization at any time. A Revocation of Authorization form is located on our website, www.countycare.com.