Appointment of Authorized Representative Form

This form lets a UnitedHealthcare Community Plan member choose someone to help or act on their behalf. The top part must be filled out by the member. If the member is not able to fill out the top part of the form, his or her legal representative may fill it out. This form must be completed and signed. Please send by fax to: 1-844-386-9286 or by mail to:

UnitedHealthcare Community and State Medicaid
PO Box 30753
Salt Lake City, UT 84130

If you have questions, please call us toll free at: 1-877-542-8997 (TTY# 711).

_____ _____
Printed Member Name UnitedHealthcare Member ID #

_____
Date of Birth

I want to allow _____ **to be my representative.**
Print Name of Authorized Representative

I allow this person to do all of these things for me:

- Discuss protected health information about me and my health care
- Make changes to my Primary Care Provider (PCP)
- Ask for an appeal or grievance
- Fill out necessary forms

I understand I can revoke permission for my Authorized Representative to act on my behalf at any time.

_____ _____
Member or Legal Representative Signature (Print Legal Representative Name)

_____ _____
Member Address Member City, State, Zip

_____ _____
Member Telephone # Today's Date