MEDICAID AUTHORIZED REPRESENTATIVE FORM

For Medicaid Applicant or Enrollee

You can choose an authorized representative

You can give a trusted person permission to talk about your Medicaid eligibility with us, see your information, and act for you on matters related to your application/renewal. This person is called an "authorized representative." You are not required to name any person or organization as your authorized representative. If you ever need to change your authorized representative, contact Medicaid. If you are a legal representative of an applicant/enrollee, submit proof to Medicaid.

Select what you would like your authorized representative to be able to do (check all that apply):

- ☐ Sign an application on your behalf.
- ☐ Complete and submit a renewal form on your behalf.
- ☐ Receive notices and other communications from Medicaid on your behalf. (If this option is selected, then all mail will be sent to the authorized representative's address only.)
- ☐ Act on your behalf in all matters regarding your Medicaid case and receive information about your Medicaid case

1. Name of authorized representative (First, Middle, Last, & Suffix) or name of organization		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number	8. ID number (if applicable)	

By signing below, I understand that I am designating the authorized representative listed above to perform the actions that I have selected above. I understand that this will remain in effect until it is canceled.

I understand that all information gathered on my situation and those persons for whom I am legally responsible is personal and confidential. My decision to appoint an authorized representative is optional, made freely, and does not relieve me of my responsibility to actively participate in the Medicaid eligibility process. I understand that the function of the authorized representative is to accompany, assist, and represent me in the eligibility determination process, and to aid in obtaining financial, medical, and/or other documentation necessary for Medicaid to determine my eligibility for Medicaid. I understand that while some of the information gathered may have no impact on my Medicaid eligibility, it may affect my liability to a third party if this information is disclosed to the third party by my authorized representative. I hereby hold the Louisiana Department of Health harmless for any claim resulting from disclosure of information to a third party by my authorized representative. I understand that if this authorization is not signed in the presence of Medicaid staff, Medicaid staff may verify this designation.

9. Your name (First, Middle, Last, & Suffix)	
10. Name of applicant/enrollee (First, Middle, Last, & Suffix) (if you are signing as their legal representative)	
11. Your relationship to applicant/enrollee (if you are signing as their legal representative)	12. SSN or Case ID for applicant/enrollee
13. Your signature	14. Date (mm/dd/yyyy)

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MEDICAID AUTHORIZED REPRESENTATIVE (continued)

For the Authorized Representative

By signing below, the authorized representative agrees to: 1) Accept responsibility for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual represented; 2) Maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual represented provided by the Louisiana Department of Health; and 3) Adhere to the regulations in 42 CFR Part 431, Subpart F and at 45 CFR 155.260(f) (relating to the confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information. If the authorized representative is an organization, this section must be completed and signed by all individuals who will act on behalf of the organization and agree to be bound the conditions of this agreement. By signing below, you certify under the penalty of perjury that any information provided on behalf of the individual represented is true and correct to the best of your knowledge.

15. Name of authorized representative (First, Middle, Last, & Suffix) or name of organization	16. ID number (if applicable)
17. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix) (if applicable)	
18. Signature of Authorized representative or individual acting on behalf of organization	19. Date (mm/dd/yyyy)

Name of additional individual(s) who will act on behalf of the organization (if applicable):

20. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
21. Signature of individual acting on behalf of organization	22. Date (mm/dd/yyyy)
23. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
24. Signature of individual acting on behalf of organization	25. Date (mm/dd/yyyy)
26. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
27. Signature of individual acting on behalf of organization	28. Date (mm/dd/yyyy)
29. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
30. Signature of individual acting on behalf of organization	31. Date (mm/dd/yyyy)