



111 East Capitol Street Suite 500  
Jackson, MS 39201

## MEMBER APPEALS AUTHORIZED REPRESENTATIVE FORM

Member Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Medicaid ID Number \_\_\_\_\_

You have the right to choose someone to act for you during your complaint/appeal with Magnolia. To choose someone to act for you, fill out this form and return it to us at the address below. You can cancel this form by sending a request in writing. If you want someone to act for you and we do not get this form, your complaint/appeal may be closed. If your complaint/appeal is closed, we will let you know in writing.

1. I give permission to \_\_\_\_\_ to act for me and receive  
**Name of Authorized Representative (Please Print)**  
information about my complaint/appeal with Magnolia or its partners.

2. Address of the person acting for me:

\_\_\_\_\_  
Street Address or PO Box

\_\_\_\_\_  
Apt #

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

( ) \_\_\_\_\_  
Phone Number: Daytime

( ) \_\_\_\_\_  
Phone Number: Evening

- By signing this form, Magnolia can give information to the person listed above about my eligibility for health care benefits and medical treatment.
- This form is good for one year from the date received by Magnolia.
- I may cancel this at any time by sending a letter to:

**Magnolia Health Plan**  
**Attn: Grievance and Appeals Coordinator**  
**111 East Capitol Street, Suite 500**  
**Jackson, MS 39201**  
**Phone: 866-912-6285 (Relay 711)**  
**Fax: 877-264-6519**

I have read this and agree to the terms.

\_\_\_\_\_  
Printed Name of Member

\_\_\_\_\_  
Signature of Member or Legal Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date