



1020 Highland Colony Parkway
Ridgeland, MS 39157

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

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

Magnolia Health Plan
Attn: Grievance and Appeals Coordinator
1020 Highland Colony Parkway
Suite 502
Ridgeland, MS 39157
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