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**

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
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**