



1020 Highland Colony Parkway, Suite 502
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