AUTHORIZED REPRESENTATIVE DESIGNATION FORM

New York Medicaid Choice

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Complete this form to name someone as your Authorized Representative with New York Medicaid Choice.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE *(please print)*

Applicant's or Enrollee's Name (Last Name, First Name)

_____

Medicaid ID _____ SSN _____

Mailing Address _____

City _____ State _____ ZIP Code _____

Date of Birth (MM/DD/YYYY) _____

Telephone Number _____ ☐ Landline ☐ Mobile

By signing, I acknowledge that in granting this authorization, this person will receive official information about my account and act on my behalf as necessary for all matters related to my account. The authorization will become effective when New York Medicaid Choice receives this completed form, and it will remain effective until I or my authorized representative inform New York Medicaid Choice that the authorization has ended.

I would like my mail from New York Medicaid Choice to be sent to:

☐ Me only ☐ Me and my Representative ☐ My Representative only

Applicant's or Enrollee's Signature

_____ Date (MM/DD/YYYY)_____

ACCEPTANCE OF DESIGNATION AS AUTHORIZED REPRESENTATIVE *(please print)*

Authorized Representative's Name (Last name, First name)

_____

Mailing Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____ ☐ Landline ☐ Mobile

Representative's language preference for written materials:

☐ English ☐ Spanish ☐ Chinese ☐ Russian

☐ Haitian Creole ☐ Korean ☐ Italian ☐ Bengali

By signing, I agree to maintain the confidentiality of any information regarding the applicant or enrollee that New York Medicaid Choice provides. I agree to fulfill all the responsibilities encompassed within the scope of this authorization as if I were the applicant or enrollee. I also agree to comply with the applicable state and federal laws concerning conflicts of interest.

If I am signing on behalf of an organization, I affirm that I will comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative's Signature

_____ Date (MM/DD/YYYY)_____

Need help with this form?

Call New York Medicaid Choice at 1-800-505-5678 (TTY 1-888-329-1541)

MM-CF-E-0425

ABOUT THIS FORM

You can give a trusted friend, relative, partner, or attorney permission to talk with New York Medicaid Choice and act for you on matters related to your account. This person is called an “authorized representative.”

An authorized representative is able to:

- Receive copies of notices and other communication; and
- Act on your behalf in all other matters with New York Medicaid Choice.

You should complete the **Authorized Representative Designation Form** if:

- You want to name someone as your authorized representative for the first time; or
- You want to change the authorized representative you named at a previous time.

If you already have a legal document that authorizes someone to act for you under New York State law, New York Medicaid Choice can accept a copy of that document in place of the Authorized Representative Designation Form. You can mail or fax this document as described below. Examples of documents that are accepted for this purpose are a court order establishing guardianship or a power of attorney form.

Duration of Authorization

This authorization is entirely voluntary. The person you designate will remain your authorized representative in perpetuity unless you withdraw your authorization. Your authorization may be withdrawn at any time by writing to New York Medicaid Choice at the address below or by calling **1-800-505-5678**.

How to Submit

Complete and sign the Authorized Representative Designation Form and submit it by fax at (917) 228-8601 or by mail at New York Medicaid Choice, PO Box 5009, New York, NY 10274.