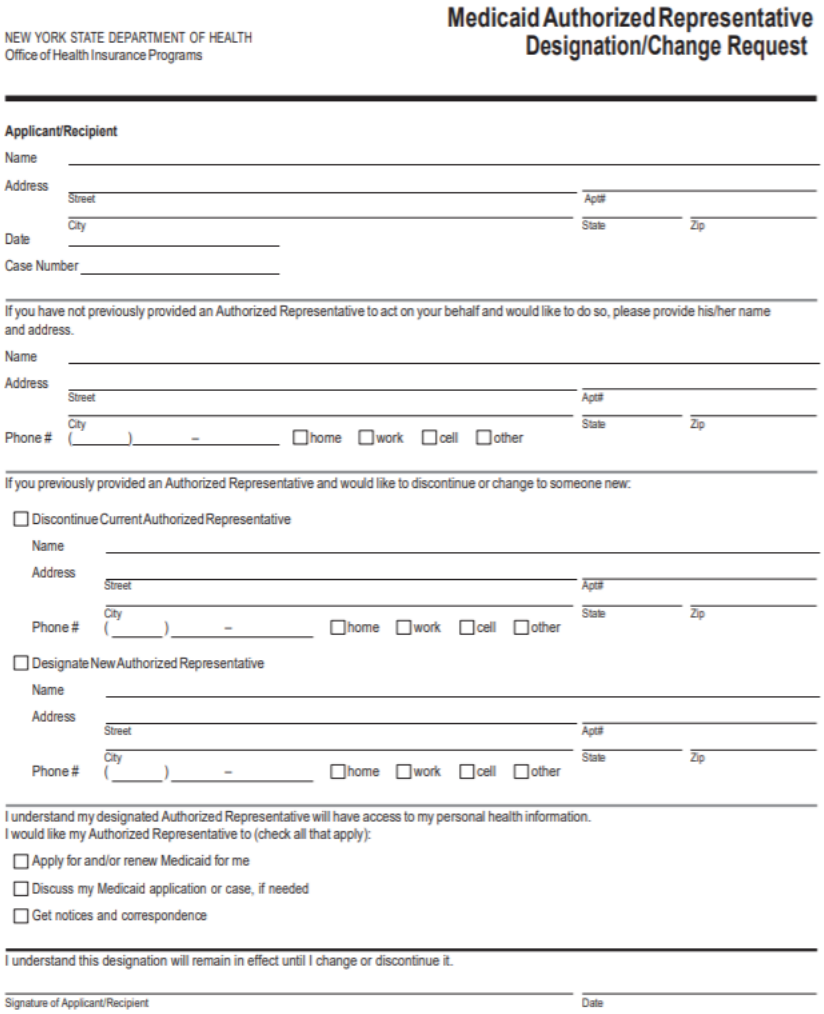
The intent of this message is to provide the Managed Long Term Care plans with information concerning requesting Personal Health and Medicaid case information for potential and current enrollees.

DOH-5247 - Medicaid Authorized Representative Designation/Change Request allows a consumer to assign, change or discontinue an authorized representative at renewal or at any time following application. This form also allows the plan to assist the consumer with their Medicaid application and renewal.



NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Authorized Representative Designation/Change Request

Applicant/Recipient

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Date _____

Case Number _____

If you have not previously provided an Authorized Representative to act on your behalf and would like to do so, please provide his/her name and address.

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Phone # (_____) _____ – _____ ☐ home ☐ work ☐ cell ☐ other

If you previously provided an Authorized Representative and would like to discontinue or change to someone new:

☐ Discontinue Current Authorized Representative

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Phone # (_____) _____ – _____ ☐ home ☐ work ☐ cell ☐ other

☐ Designate New Authorized Representative

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Phone # (_____) _____ – _____ ☐ home ☐ work ☐ cell ☐ other

I understand my designated Authorized Representative will have access to my personal health information.
I would like my Authorized Representative to (check all that apply):

☐ Apply for and/or renew Medicaid for me

☐ Discuss my Medicaid application or case, if needed

☐ Get notices and correspondence

I understand this designation will remain in effect until I change or discontinue it.

_____ (Signature of Applicant/Recipient) _____ (Date)