MOLINA HEALTHCARE OF ILLINOIS

AUTHORIZED REPRESENTATIVE DESIGNATION

To have someone else act on your behalf in an appeal, complete and return this form. The person listed will be accepted as your authorized representative. We are unable to speak with anyone on your behalf unless this form is completed, signed, and returned to us.

Molina Healthcare of Illinois
Attention: Member Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422
Fax # 855-502-5128

1. I hereby authorize the following person to act on my behalf in the filing and processing of my appeal with Molina Healthcare:

Name of Authorized Representative ____

2. Brief description of the service and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:

____

____

____

3. Address of Authorized Representative

Street Address or PO Box ____________________________________ Apt #__________

City ____________________ State ______________ Zip Code _____________

( ) ________-______________ ( )________-______________

Phone Number: Daytime Phone Number: Evening

4. Member Printed Name ____

5. Member Recipient ID Number (RIN) _______________________________

**6. Signature of Member (or legal representative) ***______________________ Date______________

*** Relationship if other than the Member**:

☐Parent ☐Guardian ☐ Conservator ☐Other – Please Specify

Please note you may revoke this authorization at any time.