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