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