absolute total care | Healthy Connections

# Appointment of Authorized Representative Form

You can give a trusted person or an organization permission to talk about your healthcare with us, see your information, and act for you on matters related to your healthcare, including the right to make decisions about how your protected health information (PHI) is used and shared. This person can also act for you on other matters, including reviews, appeals, and managed care processes. This person is called an "Authorized Representative." The Member Services Representative can release any information regarding your review and/or appeal status to your authorized representative or any member of the organization indicated on this form, unless you specify that you only want your Authorized Representative to have certain rights.
You can appoint, withdraw, or change an Authorized Representative at any time. If you ever need to change your Authorized Representative, contact Absolute Total Care. If you are a legally appointed representative for someone on this application, you do not need to complete this section.

| Member Name (printed) | Social Security Number/ Medicaid ID# |
|---|---|
| | |

## Information About the Authorized Representative

| **Name of Authorized Representative (First name, Middle name, Last name)** | | ☐ **New** ☐ **Change** ☐ **Addition** ☐ **Remove this person or organization as my authorized representative** |
|---|---|---|
| **Authorized Representative's address (Leave blank if you don't have one.)** | | **Apartment or suite number** |
| **City** | **State** | **ZIP code** |
| **Authorized Representative's phone number** | **Other phone number** | |
| **Authorized Representative's email address** | | |
| **Organization name (if applicable)** | **Unit* (if applicable)** | **ID number (if applicable)** |

*It is best to identify a specific unit for large organizations.

**OR**

## Permission to Release Information

**Is there anyone that you would like us to share information with about your review and/or appeal status?**
By completing this section, you can give permission for the following person to receive information about your review and/or appeal, but they won't have the ability to act on your behalf like an Authorized Representative. You also give Absolute Total Care permission to release information about your review and/or appeal to this additional person or organization.

| **Name of person/organization** | | | **Phone** |
|---|---|---|---|
| **Address** | **City** | **State** | **Zip** |
| **Unit (if applicable)** | **ID Number (if applicable)** | | |

| Member's signature | Date (mm/dd/yyyy) |
|---|---|
| | |

Mail your signed form to: **Absolute Total Care - 1441 Main Street, Suite 900, Columbia, SC 29201**
**Or fax to the appropriate department:**
**Member Services (1-866-912-3610) Prior Authorization (1-866-912-3606) Case Management (1-866-918-4451) Appeals (1-866-918-4457)**

**NEED HELP WITH YOUR FORM?** Visit www.absolutetotalcare.com or call us at **1-866-433-6041**. Para obtener una copia de este formulario en Español, llame **1-866-433-6041**. If you need help in a language other than English, call **1-866-433-6041** and tell the member service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.