

Appointment of Authorized Representative Form

This form lets a UnitedHealthcare Community Plan member choose someone to help or act on their behalf. The top part must be filled out by the member. If the member is not able to fill out the top part of the form, his or her legal representative may fill it out.

This form must be completed and signed. Please send by fax to: 1-866-888-1129 or by mail to: UHC C & S Project, 3315 Central Avenue, Hot Springs, AR 71901. If you have questions, please call us at: 1-877-542-8997 (TTY# 711).

Printed Member Name	UnitedHealthcare Member ID Number
Date of Birth	
I want to allow Print Name	to be my representative.

I allow this person to do all of these things for me:

- Discuss protected health information about me and my health care
- Make changes to my Primary Care Provider (PCP)
- Ask for an appeal or grievance
- Fill out necessary forms

I understand I can revoke permission for my Authorized Representative to act on my behalf at any time.

Member or Legal Representative Signature	(Print Legal Representative Name)
Member Address	Member City, State, Zip
Member Telephone #	Today's Date