MOLINA HEALTHCARE OF ILLINOIS
AUTHORIZED REPRESENTATIVE DESIGNATION FORM

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: Appeals & Grievance Coordinator
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515
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:

____

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____

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.