

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

You may have someone else act on your behalf in an appeal. The person you list below will be your representative. We cannot speak with anyone on your behalf until we receive this form. Return to us at:

Nebraska Total Care Appeals
2525 N. 117th Avenue
Omaha, NE 68164
Fax 1-844-655-0567

**Behavioral Health appeals:
Nebraska Total Care - Appeals**
12515-8 Research Blvd, Suite 400
Austin, TX 78759
Fax 1-866-714-7991

I, _____ want the following person to act

[PRINTED NAME OF MEMBER]

for me in my appeal. I understand Personal Health Information related to my appeal may be given to my **appeal representative**.

1. **Name of appeal representative** _____
[PLEASE PRINT]

2. **Address of appeal representative**
Street/PO Box/Apartment # _____
City _____ State _____ Zip _____
Daytime Phone (_____) _____
Evening Phone (_____) _____

3. **Brief description of the appeal for which appeal representative will be acting on in your behalf:**

4. **Member signature/Date:** _____
[SIGNATURE OF MEMBER, PARENT OR GUARDIAN]

Relationship to Member

Self Parent Guardian* Power of Attorney*

*Documents showing Legal Guardianship or Power of Attorney must be provided to Health Plan

5. **Appeal representative Signature/Date:** _____
[SIGNATURE OF APPEAL REPRESENTATIVE]

Relationship to Member _____