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
ATTENTION: *Appeals Department*
2525 N. 117th Ave, Omaha, NE 68164

Phone 1-844-385-2192, TTY: 1-844-307-0342, Relay 711
Fax 1-844-655-0567

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 Code _____
   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 _____