MARYLAND PHYSICIANS CARE AUTHORIZED REPRESENTATIVE DESIGNATION

To have someone else act on your behalf in an appeal or grievance, complete and return this form. The person listed will be accepted as your authorized representative. We are unable to speak with this person on your behalf unless this form is completed, signed, and returned to us.

Maryland Physicians Care
P.O. Box 893 Portland, ME 04104
Fax: 866-831-0790

1. **I hereby authorize the following person to act on my behalf in the filing and processing of my appeal or grievance with Maryland Physicians Care:**

_____

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:**

3. **Address of Authorized Representative**

_____

Street Address or PO Box **Apt#**

_____

City **State** **Zip Code**

( )

Phone Number: *Daytime* **Phone Number:** *Evening*

4. **Member Signature**

_____

Printed Name of Member (or legal representative)* **Date**

_____

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. This authorization is good for one year from the signature date and can be less if specified in box 2.

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