Heritage Health
Designation of Authorized Representative

Client Name: ______________________ Client Date of Birth: ______________ Client Social Security Number: ______________

I hereby designate __________________________ ☐ Individual ☐ Organization, to act responsibly on my behalf in assisting with my managed care enrollment and other ongoing communications with Nebraska Department of Health and Human Services; Division of Medicaid and Long-Term Care - Heritage Health.

Print Authorized Representative (Name, Address, City, State, Zip, Phone, Email):

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Scope of this authorization:

- Health plan and PCP selection on the enrollee's behalf
- Heritage Health contact information update requests on behalf of the member/enrollee
- Grievance or complaint requests on behalf of the member/enrollee
- General managed care case management with Heritage Health on behalf of the member/enrollee

I understand that this designation is valid until I modify the authorization or notify the agency in writing that the Authorized Representative is no longer authorized to act on my behalf. By signing this designation, I acknowledge that the information to be released pursuant to this designation may include material that is protected by federal or state law. I understand that the Nebraska Department of Health and Human Services cannot control what the Authorized Representative does with the released information and that such information might be redisclosed to a third party. Any released information might no longer be protected by federal or state law. I specifically authorize the Nebraska Department of Health and Human Services to discuss information released pursuant to this designation with the Authorized Representative. Failure to sign this form will not affect treatment, payment, enrollment in a health plan, or eligibility for benefits except in limited circumstances. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

Client Signature: ______________________________________ Date: ______________

Personal Representative: ☐ Parent ☐ Guardian ☐ Power of Attorney

Authorized Representative Signature: ______________________________Date:______________

If signing on behalf of an organization or entity, the signatory above must be authorized to bind the organization or entity to the terms of this authorization.

Please send completed forms to:

Heritage Health Enrollment Broker • 9370 McKnight Road • Suite 300 • Pittsburgh, PA 15237

Or fax to: **1-800-852-6311**