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 **Attn: Appeals** 2525 N. 117th Avenue Omaha, NE 68164 Fax 1-844-655-0567	**Behavioral Health appeals:** **Nebraska Total Care - Appeals** 13620 FM 620, Bldg C, Suite 300 Austin, TX 78717 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 Code _____
   Daytime Phone _____
   Evening Phone _____

3. **Brief description of the appeal for which appeal representative will be acting on 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 _____