L.A. Care
HEALTH PLAN

AUTHORIZED REPRESENTATIVE (AGENT) FORM

PURPOSE OF FORM AND MEMBER'S RIGHTS

By filling out and signing this form, I say it is okay to:

- **Have my agent in Section B of this form act on my behalf for all L.A. Care Health Plan activities including the ones listed in Section C of this form. An example of an "activity" is changing my Primary Care Provider or doctor.**
- **Have L.A. Care Health Plan and my Agent share the minimum necessary Protected Health Information (PHI) and other private facts about me to carry out these activities.**

I know that I have a right to choose anyone I wish to be my Agent.

I know that I may stop this consent at any time by sending a letter to L.A. Care Health Plan at this contact and address:

L. A. Care Health Plan
1055 West 7th Street, 10th floor
Los Angeles, CA 90017
Attn: Member Services Department

Phone # 1-888.839.9909
Medicare beneficiaries please call 1-866-522-2731

SECTION A –Member Information

<u>SECTION A INSTRUCTIONS:</u> Please fill in the table using what you see on your member identification (ID) card. If you are a new member and do not yet have an ID card, please fill in as much as you can. You can call our Member Services Department, or the number shown on your ID card and on this form for help.

Member Last Name	Member First Name	Middle Initial	Suffix
Member ID Number (from Member ID Card)	**Social Security Number (Optional)**	**Date of Birth (mm/dd/yyyy)**	**Daytime Telephone (with area code)**
Member Street Address	**City**	**State**	**Zip Code**

SECTION B –Agent Information

SECTION B INSTRUCTIONS: Please fill in the table about the person you chose to be your Agent and whom you are letting act on your behalf.

AGENT Last Name	AGENT First Name, Middle Initial	AGENT Relationship to Member	AGENT Daytime Telephone (with area code)

AGENT SIGNATURE:
I have read this form and know what it means. I hereby accept this appointment.
I certify that I have never been disqualified, suspended or prohibited from practice before the Social Security Administration or Department of Health and Human Services.

Signature: _____ **Date:** _____

AGENT Last Name	AGENT First Name, Middle Initial	AGENT Relationship to Member	AGENT Daytime Telephone (with area code)

AGENT SIGNATURE:
I have read this form and know what it means. I hereby accept this appointment.
I certify that I have never been disqualified, suspended or prohibited from practice before the Social Security Administration or Department of Health and Human Services.

Signature: _____ **Date:** _____

SECTION C –Authorized Activities and Transactions

SECTION C INSTRUCTIONS: Please read thoroughly. This consent allows your Agent(s) to act on your behalf for all L.A. Care Health Plan activities.

I say it is okay for my Agent(s) listed above to make any request and act on my behalffor all L.A. Care activities, including but not limited to:

- Changing Primary Care Provider (doctor)
- Changing IPA or medical group
- Changing Plan Partner
- Filing a grievance or appeal
- Changing member's demographic information (address, phone, etc.)
- Switching from one L.A. Care Plan Partner to another

SECTION D – Member Signature

MEMBER SIGNATURE:
I have read this form and know what it means. I know this consent goes into effect when I sign and return this form. This consent is voluntary. It will *not* change my signing up with L.A. Care Health Plan, ability to get benefits, or payment of my claims**.** I have a right to receive a copy of this consent.

_____ _____

Member's Signature **Date**