absolute total care | Healthy Connections

Appointment of Authorized Representative Form

You can give a trusted person permission to act as your healthcare representative. Your representative will have the right to make decisions about how your protected health information (PHI) is used and shared. This person can also act for you on other matters including reviews, appeals and managed care processes. This person is called an "Authorized Representative." The Member Services Representative can release any information regarding your review and/or appeal and status to your authorized representative or any member of the organization indicated on this form, unless you specify that you only want your Authorized Representative to have certain rights.

If you ever need to change your Authorized Representative, contact Absolute Total Care. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Member Name (printed)	2. Social Security Number/ Medicaid ID#

Information About the Authorized Representative

3. Name of Authorized Representative (First name, Middle name, Last name)		
4. Authorized Representative's address (Leave blank if you don't have one.)		**5. Apartment or suite number**
6. City	**7. State**	**8. ZIP code**
9. Authorized Representative's phone number	**10. Other phone number**	
11. Organization name (if applicable)		**12. ID number (if applicable)**

Please check one:

☐ The representative named above is to be given all of the rights that would be given to the member about the PHI.

☐ The representative named above will represent the member ONLY through the following specified rights:

Please print this form, then sign it on the line below before submitting. By signing, you authorize the person named above to act as your Authorized Representative. If you chose to give your Authorized Representative all of the rights that would be given to the member about the PHI, then the Authorized Representative will get official information and act for you on all future matters with Absolute Total Care. Otherwise, your Authorized Representative will only represent you and hold the rights that you specified above.

13. Member's signature	14. Date (mm/dd/yyyy)

Mail your signed form to:
Absolute Total Care
1441 Main Street Suite 900
Columbia, SC 29201
Or fax to the appropriate department:
Member Services(1-866-912-3610) Prior Authorizations(1-866-912-3606) Case Management(1-866-918-4451) Appeals(1-866-918-4457)

NEED HELP WITH YOUR FORM? Visit www.absolutetotalcare.com or call us at **1-866-433-6041**. Para obtener una copia de este formulario en Español, llame **1-866-433-6041**. If you need help in a language other than English, call **1-866-433-6041** and tell the member service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.