Molina Healthcare of Michigan

Authorized Representative Designation

To have someone else act on your behalf on 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 anyone on your behalf unless this form is completed, signed, and returned to us.

Molina Healthcare of Michigan
Attention: Appeals & Grievance Coordinator
PO Box 182273
Chattanooga, TN 37422
Fax: (248)925-1799

Member Information

Member Name: _____ Date of Birth: _____

Member ID Number (on your Molina Healthcare ID card): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

Authorized Representative Information

I (the member) hereby authorize the following person to act on my behalf in the filing and processing of my appeal with Molina Healthcare:

Name of Authorized Representative: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Alternative Phone Number: _____

Relationship: ❑ Parent ❑ Guardian ❑ Conservator ❑ Other: _____

Briefly describe the service and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:

Member Signature

Print Member Name:	Date:
Signature of Member:	Date:

Acceptance of Appointment

I (the Authorized Representative) hereby accept the subject Authorized Representative appointment.

Print Name of Authorized Representative:	Date:
Signature of Authorized Representative:	Date:

Please note you may revoke this authorized representative designation at any time by contacting Molina Healthcare.

If you have any questions, please call Molina Healthcare Member Services at (888) 560-4087 or (248) 925-1700.