



**MOLINA HEALTHCARE OF ILLINOIS
AUTHORIZED REPRESENTATIVE DESIGNATION**

To have someone else act on your behalf in an appeal, 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 Illinois
Attention: Appeals & Grievance Coordinator
1520 Kensington Rd., Suite 212
Oak Brook IL 60523
Fax # 855-502-5128

1. I 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 _____

2. Brief description of the service and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:

3. Address of Authorized Representative

Street Address or PO Box _____ Apt # _____

City _____ State _____ Zip Code _____

() _____ - _____ () _____ - _____

Phone Number: Daytime

Phone Number: Evening

4. Member Printed Name _____

5. Member Recipient ID Number (RIN) _____

6. Signature of Member (or legal representative) * _____ **Date** _____

* Relationship if other than the Member:

- Parent Guardian Conservator Other – Please Specify

Please note you may revoke this authorization at any time.