Magellan HEALTHCARE

Designation of Authorized Representative Form

Re: Benefit Plan: Medicaid and Long Term Care- Magellan Managed Care

Facility/Provider: _____________________________

Service Date(s): _____________________________

I ____

(Printed full name of member)

hereby authorize _______________________________

(Full name of member's representative/provider)

to act as my authorized representative in the appeal process regarding the services referenced above.

________________________________ ______________

Signature of member/legal guardian Date

1221 N St Ste 325 Lincoln, NE 68508 Main 800-424-0333 Fax 800-410-3293

Appeals Department

©2015 Magellan Health, Inc.