AUTHORIZED REPRESENTATIVE DESIGNATION FORM

You may have someone else act on your behalf in an appeal. The person you list below will be your representative. We cannot speak with anyone on your behalf until we receive this form. Return to us at:

Nebraska Total Care **Attn: Appeals** 2525 N. 117th Avenue Omaha, NE 68164 Fax 1-844-655-0567	**Behavioral Health appeals:** **Nebraska Total Care - Appeals** 13620 Ranch Road 620 N, Bldg 300C Austin, TX 78717-1116 Fax 1-866-714-7991

I, _____ want the following person to act
[PRINTED NAME OF MEMBER]
for me in my appeal. I understand Personal Health Information related to my appeal may be given to my **appeal representative**.

1. **Name of appeal representative** _____
[PLEASE PRINT]

2. **Address of appeal representative**
Street/PO Box/Apartment # _____
City _____ State _____ Zip Code _____
Daytime Phone _____
Evening Phone _____

3. **Brief description of the appeal for which appeal representative will be acting on your behalf:**
_____
_____

4. **Member signature:** _____ **Date:** _____
[SIGNATURE OF MEMBER, PARENT OR GUARDIAN*]
Relationship to member
☐ Self ☐ Parent ☐ Guardian* ☐ Power of Attorney*
*Documents showing Legal Guardianship or Power of Attorney must be provided to Health Plan

5. **Appeal representative signature:** _____ **Date:** _____
[SIGNATURE OF APPEAL REPRESENTATIVE]
Relationship to Member _____