AUTHORIZED REPRESENTATIVE DESIGNATION FORM

You can use this form if you would like someone else to be able to talk to Steward Health Choice and act on your behalf. This person is called an authorized representative.

Note: An authorized representative can act on your behalf in all matters with Steward Health Choice, and may receive personal information about you until we receive a cancellation notice.

How do I choose an authorized representative?

An authorized representative should be a person or organization that you trust to act on your behalf. It is common for members to choose a parent/guardian, spouse, or other trustworthy person who agrees to provide assistance. The person you choose as your authorized representative will need to sign this form as well (please see Part B below).

Can I choose more than one person as an authorized representative?

Yes, you may select more than one person to serve as an authorize representative. Each of these individuals must provide their approval by completing a signed authorized representative form. Each representative must fill out a separate form.

Do I have to select an authorized representative?

No. You do not have to select an authorized representative. You may choose not to sign this form for any reason and that choice will not affect the enrollment in, or eligibility for benefits from Steward Health Choice.

How does an authorized representative designation end?

If you decide that you no longer want an authorized representative, you may notify us by phone, mail, or fax (see contact information below) when you want the designation to end. The notice must include:

- Your name
- Address
- Date of birth
- Name of your authorized representative
- A statement that the designation has ended
- Your signature or, if you cannot provide written notice, the signature of someone acting on your behalf.

In addition, if your authorized representative notifies us that they are no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

How do I submit this form?

There are two ways that you can submit this form:

1. Submit form by mail to:

   Steward Health Choice
   Attention: Authorized Representative Form
   PO Box 298
   Westwood, MA 02090
2. Submit form by fax to: 480-760-4708

Questions about the Authorized Release Form should be directed to Member Services at 1-855-860-4949.

INSTRUCTIONS

On page two (2) of the form, you should complete Part A. On page three (3) of the form, your authorized representative should complete Part B. You may choose to submit Part A and Part B of the form separately, by checking the box below. If you choose to submit separately, please separate Part A and Part B or have your authorized representative complete a copy of the form. Both parts must be completely filled out for the authorized representative designation to take effect.

Part A: To be filled out by member. Please print, except for signature.

Member's Name (First, Last)	Member's Steward Health Choice ID Number
Member's date of birth (MM/DD/YYYY)	Member's email address
Authorized representative's name (First, Last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	

I certify that I have chosen the above listed person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Member's signature	**Date**

☐ Check this box only if **Part B** of the form will be submitted separately

Part B: To be filled out by authorized representative. Please print, except for signature.

Member's Name (First, Last)	Member's Steward Health Choice ID Number
Authorized representative's name (First, Last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	
Authorized representative's relationship to member	Authorized representative's date of birth (MM/DD/YYYY)

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by Steward Health Choice.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	**Date**

☐ Check this box only if **Part A** of the form will be submitted separately