Authorized Representative Form

Section 1. Who is the Patient?

Last Name	First Name	Middle Initial

Subscriber Number From ID Card XXX-XX-	Employer Name	Date of Birth (MM/DD/YYYY)	Phone Number

Street Address	City	State	Zip Code

I hereby authorize the individual, provider or entity listed below to act as my authorized representative in order to act on my behalf to pursue an grievance and/or external review of MagellanRx Management's denial/non-authorization for services requested for me by the provider/facility with the Magellan Grievance Department, 4801 East Washington Street, Phoenix, AZ 85034, FAX: 800-424-7648.

Section 2. Individual/Provider/Entity Information

Name (provider or facility)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 3. Services

Date(s) of service:	Level of care ☐ Inpatient ☐ Residential treatment ☐ Partial hospital ☐ Intensive outpatient ☐ Outpatient ☐ Other: _____

I understand that this approval will expire upon completion of the all grievance options offered by the benefit plan.

Section 4. Signature of the Patient or Personal Representative (if applicable)

Signature_____Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required): _____

If you have any questions about anything on this form, or how to fill it out, we can help. Please call 888-272-1346.

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.