Antidote Health Plan of Arizona, Inc.
Antidote Health Plan of Ohio, Inc.

Authorized Representative Form

If you choose to have someone be your representative to communicate with Antidote Health on your behalf, complete sections 1-3. Your personal representative may act for you in most health care matters, and may use, receive, and/or disclose your Protected Health Information (PHI). If you have any questions, please call Member Services at 1-888-623-3195. For TTY/TDD users, dial 711.

Please fax the completed form to 1-347-296-3528 OR mail to
Attn: Member Services, Antidote Health Plan, PO Box 39638, Solon, OH 44139

Section 1 – Appointment of Representative

To be completed by the Member or Minor's parent/guardian.

NAME OF MEMBER:	MEMBER ID:	DATE OF BIRTH:
ADDRESS:		TELEPHONE NUMBER:
NAME OF MINOR'S PARENT/GUARDIAN:	SIGNATURE OF MINOR'S PARENT/GUARDIAN:	DATE:

Section 2 – Authorized Use and/or Disclosure

Check each box to acknowledge that you have read each condition.

☐ I authorize the representative to make any request, file and obtain appeals and grievances information, receive any notice in connection with my appeal or health care services, wholly in my stead.

☐ I acknowledge that my authorization is voluntary. I understand that I may revoke this appointment at any time by giving written notice to Attn: Member Services, Antidote Health Plan, PO Box 39638, Solon, OH 44139

☐ This representative designation expires on (enter Month/Day/Year): ______________________

(If no expiration date is provided, this appointment is in effect until revoked in writing).

☐ I authorize Antidote Health Plan, Arizona Department of Insurance of Insurance and Financial Institutions or Ohio Department of Insurance to release any of my Personal Health Information and/or Identifiable Health Information to my appointed representative in order for them to act on my behalf and/or my child's behalf.

☐ This authorization is limited to: ______________________

Section 3 – Acceptance of Appointment as Authorized Representative

To be completed by the representative(s).

NAME OF AUTHORIZED REPRESENTATIVE #1:	NAME OF ORGANIZATION (IF APPLICABLE):	RELATIONSHIP/PROFESSIONAL STATUS:
ADDRESS:		TELEPHONE NUMBER:
☐ MY POWER OF ATTORNEY FOR HEALTH CARE DECISIONS OR OTHER LEGAL DOCUMENT IS ATTACHED (CHECK IF APPLICABLE)		
SIGNATURE OF AUTHORIZED REPRESENTATIVE #1:		DATE:
NAME OF AUTHORIZED REPRESENTATIVE #2:	NAME OF ORGANIZATION (IF APPLICABLE):	RELATIONSHIP/PROFESSIONAL STATUS:
ADDRESS:		TELEPHONE NUMBER:
☐ MY POWER OF ATTORNEY FOR HEALTH CARE DECISIONS OR OTHER LEGAL DOCUMENT IS ATTACHED (CHECK IF APPLICABLE)		
SIGNATURE OF AUTHORIZED REPRESENTATIVE #2:		DATE: