NOTE: THE EXECUTION OF THIS FORM IS NOT REQUIRED. PLEASE READ THIS DOCUMENT BEFORE SIGNING.

AUTHORIZATION TO REPRESENT AND TO RELEASE OF INFORMATION

I, **_____,** residing at_____, do hereby authorize **CarePlus Health Plans, Inc**., (CPHP) to act as my representative for the purpose of securing benefits under the Medicare Savings Program or the Medicaid Program, including completion and submission of application materials (paper or electronically) and / or appealing denial of an application under such programs.

I, **_____,** further authorize CPHP to contact private businesses and public agencies on my behalf in order to secure information required by the State or Federal agencies.

I, **_____,** further authorize the **State of Florida Department of Children and Families** or any other agency acting under the Florida State Medicaid Program, and / or the **Social Security Administration** to release any information regarding the status and / or the disposition of my application / file to **CPHP**.

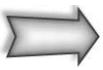
This authorization shall remain in effect until revoked in writing by me or my representative **and** is limited to the acts above; CPHP as my Authorized Representative may not sign any document(s), make enrollment decisions, file grievances, requests for an initial decision (coverage determination) or appeals on my behalf.

I understand that CPHP is not responsible for the accuracy of the information provided by me or on my behalf to complete State or Federal applications.

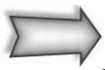
I agree not to hold CPHP responsible of any claims, liability, judgments, damages, or costs incurred by CPHP as a result of any inaccurate information provided.

_____ **Yes,** I would like to extend this Authorization to Represent to include securing healthcare / financial assistance benefits under other State or Federal programs.

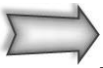
_____ **No,** I do not want to extend this Authorization to Represent to include securing healthcare benefits under other State or Federal programs.



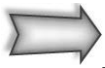
_____
Member's Social Security Number



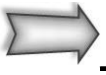
_____
Signature of Member/ Principal



_____
Date of Birth



_____
Date



_____
Medicare #

_____
Witness

CarePlus Health Plans, Inc. complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. Any inquiries regarding CarePlus' non-discrimination policies and/or to file a complaint, also known as a grievance, please contact Member Services at 1-800-794-5907 (TTY: 711). From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.
Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.