1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527

866-606-3700 (TTY: 711)
ILmeridian.com

MERIDIAN MEDICAID PLAN (MERIDIAN)

AUTHORIZED REPRESENTATIVE DESIGNATION

To have someone else act on your behalf in an appeal, complete and return this form. The person listed will be accepted as your authorized representative. We are unable to speak with anyone on your behalf unless this form is completed, signed, and returned to us.

Meridian
Attn: Meridian Appeals Dept.
PO Box 716
Elk Grove Village, IL 60009
Fax: 833-383-1503

1. I hereby authorize the following person to act on my behalf in the filing and processing of my appeal with Meridian: (Name of Authorized Representative)	
2. Brief description of the service and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:	
3. Address of Authorized Representative	
Street Address or PO Box	
City State	Zip Code Apt #
Phone Number: Daytime	Phone Number: Evening
( )	( )
4. Member Printed Name	
5. Member Recipient ID Number	
6. Signature of Member (or legal representative)*	Date
* Relationship if other than the Member: ☐ Parent ☐ Guardian ☐ Conservator ☐ Other – Please Specify _____ Please note you may revoke this authorization at any time.	