

Mojave Crest Assurance Company

AUTHORIZED REPRESENTATIVE FORM

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Member First Name: Jules	MI:	Last Name: Arden	
Street Address: 2675 Westwind Terrace	City: Las Vegas	State: NV	Zip Code: 89146
Email: j.arden.71@gmail.com	Home Phone #:	Cell Phone #: (702) 555-6732	
Member ID#: KPX658320914		Date of Birth (MM/DD/YYYY): 11/09/1971	
This form is to: ☒ Appoint a representative to act on my behalf (able to make changes) ☐ Allow a representative to have access to my information (access only, cannot make changes)			
1 st Representative First Name: Avery	MI:	Last Name: Solis	
Street Address: 4827 Silver Mesa Drive	City: Las Vegas	State: NV	Zip Code: 89117
Email: asolis@griffinmedical.org	Phone #: (702) 555-8431	Cell Phone #:	
Relationship to Member: doctor			
This appointment is for: ☒ For all purposes related to my membership in my health plan benefits. Only for (check all that apply): ☐ Medical (e.g. care management, authorizations, transportation) ☐ Enrollment (e.g. eligibility) ☐ Premium/Financial (e.g. monthly payments, Explanation of Benefits) ☐ Claims (e.g. billing) ☐ Grievance/Appeal (e.g. file a complaint or appeal) ☐ Sensitive Services (e.g. HIV/AIDs, pregnancy, sexually transmitted diseases)			

This authorization is effective:☒ From 5 / 5 / 2025 to 5 / 6 / 2026☐ Until I am no longer enrolled with plan.***Note:** For Medicare Plus DSNP, the appointment for Grievance/Appeal is only effective for 1 year from the date signed.**This form is to:**☐ Appoint a representative to act on my behalf (able to make changes)☐ Allow a representative to have access to my information (access only, cannot make changes)**2nd Representative First Name:****MI:****Last Name:****Street Address:****City:****State:****Zip Code:****Email:****Home Phone #:****Cell Phone #:****Relationship to Member:****Date of Birth (MM/DD/YYYY):****This appointment is for:**☐ For all purposes related to my membership in my health plan benefits.**Only for (check all that apply):**☐ Medical (e.g. care management, authorizations, transportation)☐ Enrollment (e.g. eligibility)☐ Premium/Financial (e.g. monthly payments, Explanation of Benefits)☐ Claims (e.g. billing)☐ Grievance/Appeal (e.g. file a complaint or appeal)☐ Sensitive Services (e.g. HIV/AIDs, pregnancy, sexually transmitted diseases)**This authorization is effective:**☐ From ____/____/____ to ____/____/____☐ Until I am no longer enrolled with plan.***Note:** For Medicare Plus DSNP, the appointment for Grievance/Appeal is only effective for 1 year from the date signed.

I understand that my treatment, payment, enrollment, or eligibility for benefits are not affected by whether or not I sign this form.

5/5/25Jules Arden

Today's Date

Member's Printed Name



Member's Signature

5/5/25Dr. Avery Solis

Today's Date

Appointed Representative #1



Signature

Today's DateAppointed Representative #2Signature