



Robert Moser, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

Medical Representative Authorization Form

You can name a person to help you fill out the medical assistance application, including signing the application on your behalf. The person you name may also answer questions for you and use the Medical Card for you. We will be able to share information with the person. The person can be a relative, neighbor, friend or other person you trust. You may not name someone who is trying to collect a medical debt against you.

If you want to have someone act in your behalf, complete the information about this person below:

First Name _____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Telephone Number _____ Email Address _____

What is this person's relationship to you (for example: Child, Friend, Neighbor, etc.)? _____

I appoint the above named person to be my representative to apply for and manage my health insurance. This person will receive copies of any letter sent about my case and will be responsible for completing review forms, providing information and reporting changes on my behalf:

Signature _____ Date _____

Witness signatures are required if the signature above is made with a mark.

Witness _____ Date _____

Witness _____ Date _____

Please send this completed form to the office where the application was submitted. This information was provided on the Confirmation Page.