maryland health connection℠
A Service of the Maryland Health Benefit Exchange

Maryland Health Connection
P.O. Box 857
Lanham, MD 20703-0857

AUTHORIZED REPRESENTATIVE FORM – HEAU Case No.

Section I: For Applicants/Recipients: If you want an authorized representative complete questions 1-18 and submit this form mail to Maryland Health Connection, P.O. Box 857, Lanham, MD, 20703-0857. An authorized representative is a trusted person who you can give permission to act on your behalf.

1. Name of authorized representative (First Name, Middle Name, Last Name) **Maryland Office of the Attorney General, Health Education and Advocacy Unit**		
2. Address **200 St. Paul Place**		3. Apartment or Suite Number
4. City **Baltimore**	5. State **MD**	6. ZIP Code **21202-2021**
7. Phone Number **(410) 528-1840**		
8. Organization Name (if applicable) **Maryland Office of the Attorney General, Health Education and Advocacy Unit**		
9. Your Name		10. Your Phone Number
11. Your Address		12. Apartment or Suite Number
13. City	14. State MD	15. ZIP Code
16. Your ID# (found on top right under application date)		

17. Below are actions your authorized representative can do on your behalf. You must place an "X" next to all that apply. At least one "X" is required to complete your request.

A. Assist with your application		**B.** Assist with renewal of health coverage	
C. Ongoing communication with agency	X	**D.** Assist with filing an appeal	X

By signing below, you allow the person named in question 1 to act for you on your behalf.

18. Your Signature	19. Date