Ohio Department of Medicaid
INSTRUCTIONS FOR COMPLETING ODM 06723
DESIGNATION OF AUTHORIZED REPRESENTATIVE

A Medicaid authorized representative (AR) is a person or organization who can act on behalf of an individual to help apply for and/or keep Medicaid coverage.

Naming an AR is optional and can be time limited. Individuals may choose to have more than one AR. The AR designation must be in writing. Individuals may complete the ODM form 06723 and submit to the local County Department of Job and Family Services (CDJFS). A separate form is needed for each AR when there is more than one AR designated. More information about requirements and responsibilities for authorized representatives may be found in Ohio Administrative Code rule 5160-1-33.

Section 1 Designation of Authorized Representative

Name of Applicant/Recipient	The name of the individual who is choosing to designate an authorized representative.
Street address City, State, Zip	The residential address of the applicant/recipient or the physical location of the applicant/recipient at the time of completing this form (a nursing home, for example).
Medicaid billing number or Social Security Number (SSN)	The 12-digit Medicaid identification number or Social Security Number of the applicant/recipient.
I hereby authorize the following person or entity to act as my representative. This authority lasts until _____ (specify a date or event), or until it is revoked by me in writing	You may choose how long the individual, entity, or organization can be designated as your authorized representative. Enter a specific date or event in this field to terminate the authorized representative designation at a certain point in time. If no date is specified, the designation of the authorized representative named on this form will last until it is revoked in writing.
Name of Representative	Complete this field if the authorized representative is an individual or a specific individual within an entity or organization. If a specific individual within an entity or organization is identified, but the entity or organization is not listed under “Company”, information under this authorization will only be shared with that specific individual. This field may be left blank if the authorized representative is an entity or organization and no specific individual from the entity or organization is named. In such case, only the “company” field should be completed.
Title	Title of the authorized representative, if applicable. This field may be left blank if the authorized representative is an entity or organization and no specific individual is named. In such case, only the “company” field should be completed.
Company	Complete this field only if the authorized representative is an entity or organization as a whole. If a company is identified in this field, a specific individual may also be identified by completing the “Name of Representative” and “Title” fields above. If only a specific individual is identified,

	but not the company, the ODM 06723-I (5/2020) Page 2 of 3 information under this authorization will only be shared with that individual within the entity or organization. Leave this field blank if the authorized representative is an individual not affiliated with an entity or organization (such as a family member).
Home Phone	The primary telephone number where the authorized representative may be reached.
Work Phone	The work or secondary telephone number where the authorized representative may be reached (if applicable).
E-mail address	E-mail address where the authorized representative may be reached (if applicable).
Mailing address City, State, Zip	The mailing address of the authorized representative. While this authorization is in effect, all notices sent by the County Department of Job and Family Services (CDJFS) or the Ohio Department of Medicaid (ODM) will also be sent to the authorized representative.
I authorize my representative to do the following on my behalf	Select “act on my behalf in all matters with the agency…” to grant broad permission to the AR OR Choose specific actions you would like your authorized representative to help with (check all boxes that apply).
Signatures	Must be signed by the applicant/recipient named in this document and the authorized representative to be designated.
Signature of Person Granting Authority	Signature of the applicant/recipient or parent/guardian if the individual is a minor. If the person granting authority is also the applicant/recipient’s guardian or power of attorney, documentation of this designation should be submitted in addition to the completed form.
Date	Enter the date in which the person granting authority signed the document.
Signature of Authorized Representative	If the authorized representative is an entity or organization, a representative from such entity or organization should sign in this field.
Title	Complete this field if the authorized representative is a specific individual within an entity or organization, or if the authorized representative has another title such as power of attorney or guardian.
Date	Enter the date in which the authorized representative signed the document.

The following section must be completed if the authorization in Section 1 is intended to allow the use or disclosure of protected health information (PHI)

Section 2 Authorization for the Use and Disclosure of Protected Health Information

Name of applicant/recipient	The name of the individual from Section 1 who chose to designate an authorized representative.
Case Number/Medicaid ID	Existing case number or Medicaid ID of the applicant/recipient (if applicable). If you have ever been issued a Medicaid ID, enter it here.
Date of Birth	Date of birth of the applicant/recipient.
Address City, State, Zip code	The residential address of the applicant/recipient or the physical location of the applicant/recipient such as a nursing home at the time of completing this form.
I hereby authorize the use or disclosure of my protected health information (PHI) as described below.	By signing this document, you acknowledge that you understand the following types of information are considered PHI: - Medical records - Substance abuse care - Vision care - Reproductive care - Mental health care - Communicable disease - Pharmacy - HIV/AIDS - Dental records - Psychiatric care
The PHI may be disclosed:	This field must be completed to indicate what PHI from the list above that you would like to share. If all PHI from the list above can be shared, state “All.” If some but not all types of PHI from the list above can be shared, indicate the type(s) of PHI that may be shared.
The information is being released for the following purpose(s)	You may choose to complete this field to state the reason for sharing this information.
Terms and conditions	By signing this form, you acknowledge that you understand these terms and conditions.
Signature of Applicant/Recipient	The individual who is choosing to designate an authorized representative must sign in this field.
Date	Enter the date on which the applicant/recipient signed the form.

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