ATTESTATION:

I hereby attest that I have the ability to make medical decisions on behalf of:

WellCare's Member Name: _____

Member ID: _____ (if known)

Medicare Number: _____

Medicaid Number: _____

For example:

I am the court-appointed legal guardian, or I have a valid durable health care power of attorney, or I am able to make medical decisions under state surrogacy consent laws for the WellCare Member.

I further confirm that documentation of this authority can be supplied upon request to the Centers for Medicare & Medicaid Services (CMS).

_____ _____

Representative Signature Date

My contact information is as follows:

Name (print):_____

Address: _____

Telephone: (home) _____

(Cell) _____ (optional)

Email:_____ (optional)

Preferred method of contact: _____

I wish plan correspondence, documents, benefit information, mailings, bills, etc., to be mailed to: (check one)

My address ☐ The WellCare Member's address ☐

Witness: (cannot be Representative, WellCare member or person associated with Health Care Facility)

Name_____ Date: _____

Name _____ Date: _____