



Check all that apply:

- I do **NOT** want my services to stay the same while my Plan Appeal is being decided.
- I request a Fast Track Appeal because a delay could harm my health.
- I enclosed additional documents for review during the appeal.
- I would like to give information in person.
- I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with Molina before?  
YES  NO
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind.  
YES  NO

**Requester (person asking for me):**

Name: \_\_\_\_\_ E- mail: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_

**Enrollee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Requester Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.*

