NYS Office for People with Developmental Disabilities

Medicare Part D Appointment Form

This form is to be used by anyone other than a guardian or parent of a minor and only for Medicare beneficiaries who do not live in a residence certified or operated by OPWDD. The person appointed in this form will have the authority to enroll the beneficiary in a Medicare prescription drug plan and to change prescription drug plans and/or to act in the Part D review process for the beneficiary pursuant to 14 NYCRR Section 635-11.3(d). To act in the Part D review process means doing any of the following: filing a grievance; submitting a complaint to the quality improvement organization; requesting and obtaining a coverage determination (including exception requests and requests for expedited procedures); filing and requesting appeals and dealing with any part of the appeals process.

Instructions:

1. Please complete all fields on page 1 of this form. Please be sure to sign and date the bottom.
2. Check the appropriate box describing the type of appointment.
3. Retain original.

Please Print

Name

Street Address

City	State	Zip

Relationship to beneficiary:

- ☐ spouse
- ☐ parent
- ☐ adult child
- ☐ adult brother or sister
- ☐ adult family member (please give relationship _____)
- ☐ adult friend
- ☐ advocate
- ☐ correspondent

The person appointed by this form will have the authority to: (check all that apply)

- ☐ Enroll the beneficiary in a Medicare Part D prescription drug plan and change plans for the beneficiary.
- ☐ Act in the Part D review process for the beneficiary.

I am the _____ of _____, who is a beneficiary receiving non-residential services from OPWDD or from a private agency certified, authorized or funded by OPWDD and (please choose one of the following boxes):

☐ I appoint _____residing at _____.

☐ I appoint the Executive Director of _____, an agency certified, authorized or funded by OPWDD. I understand that the Executive Director may appoint a designee to act on his or her behalf.

☐ I appoint the Developmental Disabilities State Operations Office (DDSOO) Director of _____, _____ DDSOO. I understand that the DDSOO Director may appoint a designee to act on his or her behalf.

This appointment supersedes any prior appointment I may have made.

Signature _____ Date_____

See following page for Executive Director's or DDSOO Director's Designation

Executive Director's or DDSOO Director's Designation

This page may be used to document the assignment of a designee to act on behalf of the Executive Director or DDSOO Director when applicable.

The persons whose names and signatures appear below attest that the Executive Director or DDSOO Director has designated them to make enrollment decisions for the beneficiary (if he or she has appointed the Executive Director or DDSOO Director to make these decisions) and/or to act in the Part D review process for the beneficiary (if he or she has appointed the Executive Director or DDSOO Director to act):

Designee(s)

_____	_____
Name	Signature
_____	_____
Name	Signature
_____	_____
Name	Signature