NYS Office for People with Developmental Disabilities
Medicare Part D
Statement of Authority
For Beneficiary Who Does NOT Live in a Residence Certified or Operated by OPWDD

This form is to be used by an adult family member, adult friend, adult advocate or adult correspondent of a Medicare beneficiary who does not live in a residence certified or operated by the Office For People With Developmental Disabilities (OPWDD). It states the authority for the person to make decisions regarding the Medicare prescription drug benefit for the beneficiary and the basis for this authority.

Instructions:

1. Please complete all fields on this form. (Note: If you are enrolling the beneficiary in a plan you should not fill in a beneficiary plan ID number.)
2. Check the appropriate boxes.
3. Please print name and sign and date the bottom.
4. Retain original.

Name of Beneficiary	Date of Birth	Medicare Number

Name of Prescription Drug Plan	Beneficiary's Plan ID Number

The above named beneficiary is over 18 years of age. This person does not have a guardian and has been determined to be without the ability to make decisions about (check all that apply):

☐ Enrollment in a Medicare prescription drug plan.

☐ Acting in the Medicare Part D review process. This includes filing grievances, submitting complaints, requesting and obtaining coverage determinations (including exception requests and requests for expedited procedures), filing and requesting appeals and dealing with any part of the appeals process.

Relationship to the beneficiary. Please check **one** of the following:

☐ Spouse
☐ Parent
☐ Adult child
☐ Adult sibling
☐ Adult family member
☐ Adult friend, advocate or correspondent

Pursuant to 14 NYCRR 635-11, I am authorized to make enrollment decisions and/or act in the Medicare Part D review process if the beneficiary lacks the ability to do so.

Name _____ Date_____

Signature_____

Telephone Number _____