Jennifer Krupp, MPH, MBA, PHP, Administrator
Division of Consumer Health Services

Stacie Weeks, JD, MPH, Director
Nevada Health Authority

CONSENT TO SERVE AS AN AUTHORIZED REPRESENTATIVE IN ORDER TO FACILITATE ENROLLMENT FOR APPLICANT

IMPORTANT INFORMATION FOR ANY PERSON APPOINTING AN AUTHORIZED REPRESENTATIVE AND FOR ANY INDIVIDUAL PERSON OR ORGANIZATION THAT IS AGREEING TO SERVE AS AN AUTHORIZED REPRESENTATIVE:

- The Silver State Health Insurance Exchange (Exchange) is responsible for operating and managing Nevada Health Link, Nevada's health insurance marketplace where consumers can shop and enroll in health or dental coverage. ***(NRS 695I.210)***
- An applicant can appoint an Authorized Representative to act on his or her behalf in applying for Nevada Health Link eligibility determination or redetermination.
- The Authorized Representative may act on behalf of the applicant in all matters related to the Exchange/Nevada Health Link. ***(45 CFR 155.227(a))***

AUTHORIZED REPRESENTATIVE CONSENTS TO:

- Maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant provided by the Exchange. ***(45 CFR 155.227(a)(3))***
- Be responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the applicant he or she represents. ***(CFR Sec 155.227(4))***
- Abide by federal and state laws and regulations pertaining to the Exchange.

AUTHORIZED REPRESENTATIVE APPOINTMENT:

I, the applicant, hereby appoint and give permission to the Authorized Representative identified below to assist with my application and enrollment in a Qualified Health Plan (QHP), Qualified Dental Plan (QDP), Stand-Alone Dental Plan (SADP), and/or Nevada Medicaid plan offered through Nevada Health Link. By completing and signing this form, I agree to allow my Authorized Representative to collect required information and pursue enrollment on my behalf, in accordance with the Nevada Health Link Privacy Policy and applicable state and federal laws.

Applicant Name: _____ Date of Birth:_____
Address:_____
Email: _____Phone Number:_____
Case/Application ID#: _____
List Other Dependents Name and Date of Birth (i.e. Spouse, children): _____
_____

*Authorized Representative is any person or organization chosen by the consumer to act on their behalf with the Nevada Health Link and facilitate application submission and enrollment. Examples of Authorized Representatives include: a family member or another trusted person such as a Certified Enrollment Professional (i.e. licensed broker or navigator).
Nevada Health Link Privacy Notice can be found at https://www.nevadahealthlink.com/about-nevada-health-link/privacy-policy/. To report fraud, abuse or file a privacy complaint email NVHLprivacy@nvha.nv.gov.

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- I, the applicant, hereby appoint _____ to serve as an Authorized Representative to facilitate my application on behalf of myself and anyone listed on this application.
- I, the applicant, understand that my Authorized Representative may discuss my application with Nevada Health Link, see and disclose necessary information to Nevada Health Link, and act on my behalf on matters related to my application, including receiving information about my application and signing my application on my behalf.
- I, the applicant, understand that this information will be used for eligibility determination for enrollment in Nevada Health Link health and/or dental plans, Advanced Premium Tax Credits (APTC), and/or other public health insurance programs such as Nevada Medicaid or Nevada Check-up.
- I, the applicant, understand that individuals on this form have the right to review the Nevada Health Link Privacy Notice before signing the form and to request a copy at any time.
- I, the applicant, consent to the use of my Social Security Number by my Authorized Representative for the purpose of identification.
- I, the applicant, attest that the information provided on this form is accurate and complete, to the best of my knowledge and/or belief. I understand and agree that any omissions or incorrect statements knowingly made on this form may invalidate the designation of my Authorized Representative.
- I, the applicant, understand that I may revoke this authorization by notifying my Authorized Representative with Nevada Health Link in writing. If I revoke the authorization, it will not affect any actions already taken by my Authorized Representative.
- I, the applicant, understand that I may request a copy of this completed authorization form.

For purposes of facilitating Nevada Health Link enrollment, unless revoked, this authorization permits my Authorized Representative to facilitate eligibility determination and enrollment on behalf of myself, and anyone listed on this application. Authorization can be revoked at any time by the applicant, or by the Authorized Representative if they no longer are acting or are no longer authorized to act in such capacity. ***(45 CFR 155.227(d))***

Applicant/Enrollee Signature: _____ Date: _____
Spouse's Signature (if applicable):_____ Date: _____
Authorized Representative's Signature: _____ Date:_____
Printed Name of Authorized Representative, Address, Telephone Number and, if applicable, Nevada Division of Insurance Certification No.:_____
_____
Plan Name:_____Plan Metal Type:_____
QHP:_____SADP:_____Medicaid/CHIP_____

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Nevada Health Link Privacy Notice can be found at https://www.nevadahealthlink.com/about-nevada-health-link/privacy-policy/. To report fraud, abuse or file a privacy complaint email NVHLprivacy@nvha.nv.gov.