Medi-Cal Dental Program
Authorized Representative Standard Agreement for Organizations

This standard agreement must be completed by the person or persons who will act for the organization that the Medi-Cal Dental Program member has appointed as an authorized representative.

The organization must give this signed and completed form to the Medi-Cal Dental Program Information Security/Privacy Office. This form is required by federal regulation 42 CFR Section 435.923(e) and Welfare and Institutions Code Section 14014.5(k).

Complete this form and mail to:

Medi-Cal Dental Program
Attention: Information Security/Privacy Office
P.O. Box 15539
Sacramento, CA 95852-1539

Part A: Tell us about the organization:

Organization Name:	Phone number:

Organization Mailing address (number, street, city, state, ZIP code):

Part B: Tell us about the member:

Applicant or Member Name:	Phone number:

Applicant or Member Mailing address (number, street, city, state, ZIP code):

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By signing below, I hereby accept appointment as an authorized representative for the organization named above. I understand and agree that:

- I am acting as an authorized representative for the above-named organization that the Medi-Cal Dental program member appointed as an authorized representative. I am not acting in my individual capacity.
- I have no power to act for the Medi-Cal Dental program member, except as specified by the Medi-Cal Dental program member.
- The Medi-Cal Dental program member may cancel the appointment at any time and appoint another individual or organization to act as their authorized representative.
- This agreement may not be transferred or reassigned to any person not on this form. To allow any other provider, staff member, or volunteer of the organization to act as the authorized representative, there must be a new Medi-Cal Dental program Authorized Representative Standard Agreement for Organizations.
- A Medi-Cal Dental program authorized representative appointment must not be transferred or reassigned to another individual or organization unless the Medi-Cal Dental program member authorizes it.

By signing below, I certify that:

- I will obey all state and federal laws for authorized representatives. These include, but are not limited to, laws about confidentiality of information, prohibitions against reassignment of provider claims, and conflicts of interest.
- If I am an employee or a contractor for a health care provider or facility, I will give the Medi-Cal Dental program member a written disclosure regarding:
    - My employment by or contract with the health care provider or facility.
    - Any potential conflicts of interest that may exist due to that employment or contract.

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By signing below, I certify under penalty of perjury under the laws of the State of California that the above is true and correct.

Part C: Please complete and sign below for each person:

Name of person to act as authorized representative:	Phone number:

Signature of person to act as authorized representative:	Date:

Name of person to act as authorized representative:	Phone number:

Signature of person to act as authorized representative:	Date:

Name of person to act as authorized representative:	Phone number:

Signature of person to act as authorized representative:	Date:

*All Privacy Forms can be found on the Medi-Cal Dental website at www.dental.dhcs.ca.gov under the Forms tab.

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