



CENTER FOR INDEPENDENCE – COLORADO
VETERAN CHOICE PROGRAM
AUTHORIZED REPRESENTATIVE FORM

Instructions: Please fill out any information in Sections 1 and 2, where applicable. Veterans are required to sign and date at the bottom of the form. If a Veteran has an Authorized Representative, the AR must also sign and date the form. Please submit the completed form to PremierFMS via one of the following options:

Mail

10425 W North Ave
Suite 345
Milwaukee, WI 53226

Email

CFI@Premier-FMS.com

Fax

855.334.3866

SECTION 1: VETERAN'S INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email Address: _____

Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

SECTION 2: AUTHORIZED REPRESENTATIVE'S INFORMATION *(If applicable)*

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email Address: _____

Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection. For any questions or concerns, please contact our office at 855.287.6638.

Veteran Signature: _____ Date: ____ / ____ / ____

Authorized Representative Signature: _____ Date: ____ / ____ / ____