Premier
FINANCIAL MANAGEMENT SERVICES
Part of the AssuranceSD family

INDEPENDENCE CENTER – COLORADO
VETERAN DIRECTED CARE
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	**Email**	**Fax**
10425 W North Ave Suite 345 Milwaukee, WI 53226	ICVIC@Premier-FMS.com	855.325.4668

SECTION 1: VETERAN'S INFORMATION

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

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 **855.275.3948**.

Veteran Signature: _____ Date: _____ / _____ / _____

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