

REQUEST FOR A STATE FAIR HEARING

Completing this form is voluntary. Personally identifiable information collected on this form is used to identify the case and process your request only.

Name – Member		Phone	Medicaid ID #
Mailing Address		Program <input type="checkbox"/> Family Care <input type="checkbox"/> Partnership <input type="checkbox"/> PACE	
City	Zip Code	Managed Care Organization (MCO)	
Today's Date		Effective Date of Action	
Appeal related to: <input type="checkbox"/> Eligibility <input type="checkbox"/> Cost share <input type="checkbox"/> Change to service/support <input type="checkbox"/> Care plan		Briefly describe change to service/support:	

- Yes No 1. Did you file an appeal with your MCO's Grievance and Appeal Committee?
- Yes No 2. If you answered 'yes' to question one (1), did you request the same services to continue during your appeal with the MCO?
- Yes No 3. If you answered 'yes' to question one (1), have you appeared before the MCO's Grievance and Appeal Committee?
- Yes No 4. If you answered 'yes' to question three (3), have you received a decision from the MCO's Grievance and Appeal Committee? (Please attach a copy of the decision, if available.)

Continuing your services during an appeal of a reduction, suspension or termination of a service

If you are getting benefits and you ask for a fair hearing before your benefits change, you can keep getting the same benefits until a decision on your fair hearing has been made. If you want to keep your benefits during your fair hearing, your request must be postmarked or faxed **on or before the effective date of the intended action**. If the judge decides that your MCO's decision was right, you may need to repay the extra benefits that you got between the time you asked for your fair hearing and the time that the judge makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost.

Check this box if you would like to request the same services to continue during your appeal.

Copy of your case file

You have the right to a free copy of the information in your case file related to your grievance or appeal. Information means documents, records, and other related materials. This includes any new or additional information your MCO gathers during your appeal. To request copies contact your care manager or a member rights specialist.

SIGNATURE – Member

 Date Signed

Mail or fax this form **AND** a copy of the Notice of Adverse Benefit Determination or decision letter to:

Family Care Request for Fair Hearing
c/o Division of Hearings and Appeals
PO Box 7875
Madison WI 53707-7875
Fax: 608-264-9885

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-800-777-4376 (TTY: 1-800-947-3529).

Spanish

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-800-777-4376 (TTY: 1-800-947-3529).

Hmong

CEEB TOOM: Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. Hu 1-800-777-4376 (TTY: 1-800-947-3529).

Chinese Mandarin

注意: 如果您说中文, 您可获得免费的语言协助服务。请致电1-800-777-4376 (TTY 文字电话: 1-800-947-3529)。

Somali

DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa lagu heli karaa iyadoo bilaash ah. Wac 1-800-777-4376 (TTY: 1-800-947-3529).

Laotian

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-777-4376 (TTY: 1-800-947-3529).

Russian

ВНИМАНИЕ: Если Вы говорите по-русски, Вам будут бесплатно предоставлены услуги переводчика. Позвоните по номеру: 1-800-777-4376 (TTY: 1-800-947-3529).

Burmese

ဝေးကွ່າပူပီၼ် နားဆငှါ - သဠည ခုမနွာစကားပေုဟသုပုဖစွါက၊
သင့အတြက အခမဲ့ပုဖင့ ဘာသာစကားကူညီေးရး ဝန့ဆာငွးမ်း
ရရိန်ငည။ 1-800-777-4376 (TTY: 1-800-947-3529) တြင
ဖန့းေခင့ဆိုပါ။

Arabic

تنبيه: إذا كنتم تتحدثون العربية، تتوفر لكم مساعدة لغوية مجانية. اتصلوا بالرقم 4376-777-8001 (هاتف نصي: -3529-947-8001).

Serbo-Croatian

PAŽNJA: Ako govorite srpsko-hrvatski imate pravo na besplatnu jezičnu pomoć. Nazovite 1-800-777-4376 (telefon za gluhe: 1-800-947-3529).

Independent Care Health Plan

- Provides free aids and services to people with disabilities to

communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Member Advocate/Member Rights Specialist at 1-800-777-4376, ext. 1076.