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| --- | --- |
| **Date:** [DATE OF LETTER] | **Decision made by:** [LME/MCO NAME] |
| [BENEFICIARY NAME]  | [ADDRESS LINE 1][ADDRESS LINE 2][CITY, STATE, ZIP] |
| [LEGAL GUARDIAN IF APPLICABLE] |
| MID: [BENEFICIARY MID] |
| PA #: [PA NUMBER] |
| **DIRECTIONS:** To request an Appeal, complete this form and return it to [LME] at the address or fax number below. You may return this form by fax, by mail or by hand delivery. You can also call us at [PHONE NUMBER] to ask for an Appeal. **You will still need to send us your completed form after you call.** The last day to appeal is: [DATE]. If you want your services to continue until your appeal if finished, you must check the box below or call and tell us. **We must receive your appeal by [DATE] for your services to continue during your appeal.**  |
| **I want my services to continue until my appeal is decided: □** YES **□** NO |
|   [LME NAME] Attention: [DEPARTMENT][ADDRESS LINE 1][ADDRESS LINE 2]Telephone: [XXX-XXX-XXXX]Fax: [XXX-XXX-XXXX] |
| **I WOULD LIKE TO APPEAL THE [INSERT DATE] DECISION TO REDUCE OR STOP MY SERVICES.** |
| If you need a quick decision because your life, your physical or mental health, or your ability to attain, maintain, or regain maximum function is in danger, ask for an **Expedited Appeal.** To ask for an expedited appeal, call [PHONE NUMBER] OR check the box below and fax this form to [FAX NUMBER].**□** I **AM REQUESTING AN EXPEDITED APPEAL.** |
| **□** I **am requesting a free interpreter to assist during my appeal. My primary language is:****□** Español **□** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Sign Language |
| I will *(PLEASE CHECK ONE)*: | **□ Represent** myself  | **□ Be** represented by someone else |
| **If you know now who will be your representative, complete the section below:** |
| *Name of Representative:*  |  |
| *Relationship to You:*  |  |
| *Address:* |  |
| *Telephone:* |  |

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Signature of Medicaid Recipient or Legal Guardian Date Telephone Number