|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** [DATE OF LETTER] | | **Decision made by:** [LME 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]**.** | | | |
| *Space intentionally blank* | | | |
| [LME/MCO]  Attention: [DEPARTMENT]  [ADDRESS LINE 1]  [ADDRESS LINE 2]  Telephone: [XXX-XXX-XXXX]  Fax: [XXX-XXX-XXXX] | | | |
| **I WOULD LIKE TO APPEAL THE [DATE] DECISION ON MY [SERVICE NAME] REQUEST.** | | | |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 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