FORM TO REQUEST A STATE FAIR HEARING

Are you asking for a State fair hearing because of a decision made by the Medicaid agency or by a managed care plan?

*Check one: ☐ **Medicaid Agency** ☐ **Managed Care Plan - Name of Plan:** _____

(A managed care plan can be a Medicaid physical health plan, Medicaid prepaid mental health plan, Medicaid dental plan, CHIP dental plan, or CHIP physical and mental health plan.)

This form must be submitted by the deadlines shown on the next page.

Please enclose a copy of the Medicaid Agency's denial notice or the Managed Care Plan's notice of its appeal decision or we cannot proceed with this hearing request.

If waiting for a decision about this hearing request could endanger the member's life, health, or ability to attain, maintain, or regain maximum function, call Administrative Hearings (801-538-6576) to request an expedited hearing.

*1. Name of person requesting hearing: _____ *Phone #: _____

*Street Address: _____

Email Address: _____ Fax #: _____

*2. Member's name: _____ *Medicaid ID #: _____ Date of birth: _____

3. Provider's name: _____ Provider's NPI: _____

4. Reason for hearing request: _____

_____

5. Service(s) or procedure code(s): _____ Date(s) of service(s): _____

Providers: Submit any medical records that support your position, otherwise the hearing may be delayed.

You may represent yourself or have another person represent you. If an attorney represents you, the attorney must file a Notice of Appearance to the address below. *Will an attorney represent you? ☐ Yes ☐ No

Name of representative or attorney: _____ Phone #: _____

Address: _____ State: _____ Zip: _____

_____ _____

*Signature of person requesting hearing: _____ Date: _____

Name and address of additional person(s) you would like to be notified of your hearing request:

_____

_____

All asterisked (*) items above must be completed to proceed with this hearing request.

SEND THIS FORM TO:

Via U.S. Post Office	**Via UPS or FedEx**	**Email or Fax**
Office of Administrative Hearings Division of Integrated Healthcare PO Box 143105 Salt Lake City, UT 84114-3105	Office of Administrative Hearings Division of Integrated Health Care 195 North 1950 West Salt Lake City, UT 84116	Email: utmedicaidhearings@utah.gov Fax: 801-536-0143

Administrative Hearings Telephone #: 801-538-6576

Deadlines for Submitting the Form to Request a State Fair Hearing

Box 1

If you checked **Medicaid Agency** at the top of the Form to Request a State Fair Hearing, you must send the form **within 30 days** from the date the Medicaid Agency sent a denial notice.

If you checked **Managed Care Plan (Plan)** at the top of the Request a State Fair Hearing, you must send the form **no later than 120 calendar days** from the date of the Plan's notice of its appeal decision.

Box 2

The deadlines in this box only apply if the member wants services continued during the State fair hearing.

If the member is getting service(s) related to this hearing request, does the member want the service(s) continued during the hearing? Yes ☐ No ☐ If "no" follow the instructions in Box 1 above. If "yes" follow the instructions below:

If you checked **Medicaid Agency** at the top of the Form to Request a State Fair Hearing, then the following deadline applies:

- The form **and** the member's signed request to have services continued must be sent **within 10 calendar days** of the date the Medicaid Agency's notice was sent. If the hearing decision is the same as the Medicaid Agency's decision, the member may have to pay for the services.

If you checked **Managed Care Plan (Plan)** at the top of the Form to Request a State Fair Hearing, then the following deadline applies:

- The form **and** the member's signed request to have services continued must be sent **within 10 calendar days** after the Plan sent the notice of its appeal decision. If the hearing decision is the same as the Plan's decision, the member may have to pay for the services.