**(Insert Name of LME-MCO) Reconsideration Review Form**

To request a Reconsideration Review, please complete this form and return it to **(Insert Name of LME-MCO)** by mail, fax, email, or hand delivery no later than *30 days after the mailing date of the LME-MCO Notice of Action.*

**(Insert Name of LME-MCO)**

Attention: Appeals Coordinator

 **(Insert LME-MCO Mailing Address)**

**Phone:** **(Insert Telephone Number)** **Fax: (Insert LME-MCO Fax Number)**

**E-mail: (Insert LME-MCO Email Address)**

|  |  |
| --- | --- |
| «Name» or GUARDIAN of «Name»«Street»«City», «State» «Zip»  | Beneficiary: «Name»MID: «MID»County of Origin: «County\_of\_Origin»Service Auth Request # «SAR» |

I would like to request a Reconsideration Review of **(Insert Name of LME-MCO)’s** denial of the following Medicaid services:

|  |  |
| --- | --- |
| **Service** | **Authorization Period** |
| «Service\_Requested», «Units\_Requested» units | «Dates\_of\_Service\_Requested» |

My current phone number where I can be reached is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like this decision to be reconsidered because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all that apply**:

* I would like for my current Medicaid services to continue during the Reconsideration Review. I understand that services can only continue until one of the following occurs: I withdraw the appeal; I do not request a State fair hearing within **ten (10) days** after the mailing date of an adverse Reconsideration Review decision; a State fair hearing decision adverse to me is issued; or the time period for the currently authorized services expires or the service limits for the currently authorized services are reached.
* I would like to submit additional information to be considered during the Reconsideration Review.
* I would like to review the information that is being used in the Reconsideration Review.
* I would like my authorized representative identified below to help me with this appeal.

Signature of Medicaid Beneficiary/ Legal Guardian Date

If you are acting as the authorized representative for the Medicaid beneficiary, please complete this section:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Beneficiary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Si necesita ayuda con este forma, por favor llámenos al (Insert LME-MCO Telephone Number). Diga el operador que necesita ayuda con Formulario “Reconsideration Review.”***