**State Fair Hearing**

***Information and Instructions***

***(1) What is a State fair hearing?***

Under the federal Medicaid system, after a Medicaid beneficiary has completed the first level of the “appeal” process, known as a “Reconsideration Review,” the beneficiary may file a request for a State fair hearing. A State fair hearing offers the Medicaid beneficiary the opportunity to appear before an administrative law judge when **(Insert Name of LME-MCO)** has taken an “action,” for example, if **(Insert Name of LME-MCO)** made a decision to deny, reduce, suspend or terminate Medicaid services. For more detail, see 42 C.F.R. § 438.400(b). You may request a State fair hearing by completing and timely filing (by mail or fax) the enclosed ***State Fair Hearing Request Form*** with the North Carolina Office of Administrative Hearings (OAH), *and* sending a copy to **(Insert Name of LME-MCO).** To be timely filed, the request must be received no later than 30 days after the mailing date of the Reconsideration Review decision. The mailing addresses and telephone and fax numbers for OAH and **(Insert Name of LME-MCO**) are included on the ***State Fair Hearing*** ***Request Form***. Please note that you ***must*** have completed a Reconsideration Review before you can request a Statefair hearing.

**(2) *What happens after I timely file the completed State Fair Hearing Request Form?***

You will be contacted by the Mediation Network of North Carolina and offered an opportunity for mediation in an effort to resolve your case. If your case is not resolved at mediation, or you choose not to participate in mediation, your case will proceed to a State fair hearing before an administrative law judge with OAH. If you accept a mediation but do not attend, your appeal may be dismissed*.* You will be notified by mail of the date, time, and location of your State fair hearing. To ensure you receive all notices, please notify OAH and **(Insert Name of LME-MCO)** of any changes in your address or other contact information.

**(3) *What will happen at the State fair hearing?***

You or your representative will have the opportunity to present your case to an administrative law judge. **(Insert Name of LME-MCO**) will also present its case. The administrative law judge will make a decision to uphold or overturn **(Insert Name of LME-MCO)’s** decision on your request for Medicaid services. You will receive a written copy of the administrative law judge’s decision. If you do not agree with the administrative law judge’s decision, you may ask for a judicial review in Superior Court. Go to <http://www.oah.state.nc.us/hearings/medicaid.html> for more information about State fair hearings.

**(4) *Can I continue to receive services during the State fair hearing process?***

If you received a Reconsideration Review decision that was adverse to you, and if your request for a Reconsideration Review was based on **(Insert Name of LME-MCO**) terminating, reducing or suspending your ***current*** Medicaid services ***before the expiration of the authorization***, you may continue to receive those current Medicaid services during theState fair hearing process if you meet all of the following conditions:

* You requested a State fair hearing within **ten (10) days** of **(Insert Name of LME-MCO)** mailing the Reconsideration Review decision to you;
* The State fair hearing involves the termination, suspension, or reduction of currently authorized services;
* The services were ordered by an authorized provider;
* The authorization period for the current services has not expired; and
* You requested that your services continue.

If all of these conditions are met, you may continue to receive your current services until:

* You withdraw your request for a State fair hearing;
* A State fair hearing decision adverse to you is made; or
* The current authorization expires or authorization service limits are met.

Please call **(Insert Name of LME-MCO)** at **(Insert Telephone Number)** if you have questions or need assistance.

**(5) *Can I ask someone else to represent me during the State fair hearing?***

You may represent yourself during the State fair hearing, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.

**(6) *What if I need legal assistance?***

To locate a lawyer, please call 919-677-8574 for the North Carolina State Bar Lawyer Referral Service.

**(7) *What if I have more questions?***

For questions concerning the decision **(Insert Name of LME-MCO)** made about your request for Medicaid services, please contact **(Insert Name of LME-MCO)** at **(Insert Telephone Number).** Should you have questions about the State fair hearing, please contact OAH using the contact information below, or visit  [http://www.oah.state.nc.us/hearings/medicaid.htm](http://www.oah.state.nc.us/hearings/medicaid.html)l

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| --- | --- | --- | --- |
| **Agency** | **Mailing Address** | **Telephone Number** | **Fax Number** |
| North Carolina Office of Administrative Hearings (OAH) | Attn: Clerk6714 Mail Service CenterRaleigh, NC 27699-6714 | 919-431-3000 | 919-431-3100 |
| (**Insert Name of LME-MCO)** | Appeals Department**(Insert Mailing Address of LME-MCO)** | **(Insert Telephone Number)** | **(Insert Fax Number)** |

**State Fair Hearing Request**

NAME OR GUARDIAN OF Name Telephone Number

Street MID

City, NC zip code

To request a State fair hearing with the North Carolina Office of Administrative Hearings based on **(Insert Name of LME-MCO)’s** decision to:

\_\_\_\_ deny some or all of the request for Medicaid services; or

\_\_\_\_ terminate, reduce or suspend the current Medicaid services before the expiration of the authorization

|  |  |  |
| --- | --- | --- |
| Insert the Denied Service; ***or*** the Partially Denied Service ; ***or*** the Terminated, Reduced or Suspended Service |  Authorization Period | Units |
| Enter Service |  |  |

I would like a State Fair Hearing because **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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I understand that I may be entitled to continue to receive my current Medicaid services during the pendency of the State fair hearing. If the final resolution of the appeal upholds **(Insert Name of LME-MCO)’s** decision, I understand that I may be required to pay for those services. I can call **(Insert Name of LME-MCO Contact)** at **(Insert Telephone Number)** for assistance/information about continuation of services.

**Please check one of the following:**

* I want to continue to receive my current Medicaid services during the pendency of the State fair hearing.
* I do not want to continue to receive my current Medicaid services during the pendency of the State fair hearing.

I understand I have the right to be represented at the contested case hearing by a lawyer, a relative, a friend or other spokesperson. To locate a lawyer, I can call 1-800-662-7660 for the North Carolina Health Information Project Lawyer Referral Service or 1-800-662-7407 for the North Carolina State Bar Lawyer Referral Service.

**Please check one of the following:**

* I will represent myself. Telephone Number(s) (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I will be represented by someone other than myself. If you check this box, please provide the following information:

Name(s) of Representative(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Medicaid Beneficiary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, you authorize the person(s) listed above to represent you during the State fair hearing, discuss your case and release any and all medical records or other documents and confidential information that pertain to the State fair hearing. You also attest that OAH and **(Insert Name of LME-MCO)** have both been served with this form.

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 (Signature of Medicaid Beneficiary/Authorized Representative (Required) Date

Please mail or fax this form to OAH and **(Insert Name of LME-MCO)** at the addresses or fax numbers listed below. This form must be received by [**INSERT DATE THAT IS 30 DAYS AFTER THE MAILING DATE OF RECONSIDERATION DECISION LETTER].**

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency** | **Mailing Address** | **Telephone Number** | **Fax Number** |
| North Carolina Office of Administrative Hearings (OAH) | Attn: Clerk6714 Mail Service CenterRaleigh, NC 27699-6714 | 919-431-3000 | 919-431-3100 |
|  |  |  |  |
| (Insert Name of LME-MCO) | Appeals Department(Insert Mailing Address of LME-MCO) | (Insert Telephone Number) | (Insert Fax Number) |