|  |  |  |  |
| --- | --- | --- | --- |
| **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:* |  | | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Medicaid Recipient or Legal Guardian Date Telephone Number