DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00236 (02/2020)

STATE OF WISCONSIN
Wis. Stats. § 46.287(2)(c)

REQUEST FOR A STATE FAIR HEARING

SECTION A – REQUIRED

Completing this form is voluntary. Personally identifiable information collected on this form is used to identify the case and process your request only.

Name – Member		Phone	Medicaid ID #
Mailing Address		Program ☐ Family Care ☐ Partnership ☐ PACE	
City	Zip Code	Managed Care Organization (MCO)	
Today's Date		Effective Date of Adverse Benefit Determination	

Continuing your services: If the adverse benefit determination affects your services and your request is received before the effective date, your services in most cases will not stop or be reduced. (If the judge decides that the MCO's decision was right, you may need to repay the extra services that you got between the time you asked for a fair hearing and the time that the judge makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost.)

Do you wish your services to be continued? ☐ Yes ☐ No

SECTION B

Complete only if fair hearing request is related to: ☐ Eligibility ☐ Cost Share	Why are you asking for a hearing? (Attach additional sheet if needed.)

SECTION C

Complete only if fair hearing request is related to one of the below. To request a fair hearing related to one of the below, you must first go through your MCO's appeals process.

☐ Functional eligibility screen conducted by MCO

☐ Reduction, suspension or termination of service/support

☐ Denial or limited authorization of a requested service

☐ Denial of payment for a service

☐ Care plan

☐ Failure to provide services/supports in a timely manner

☐ Involuntary disenrollment from the MCO

☐ Denial of request to dispute a financial liability

☐ Denial of request to obtain services outside the MCO's network

☐ Failure of the MCO to make an appeal decision within the required timeframe

Why are you asking for a hearing? (Attach additional sheet if needed.)

☐ Yes ☐ No 1. Did you file an appeal with your MCO's Grievance and Appeal Committee?
Date you filed the appeal:

☐ Yes ☐ No 2. Did you request the same services to continue during your appeal with the MCO?

☐ Yes ☐ No 3. Have you received a written decision from the MCO's Grievance and Appeal Committee? Attach a copy of the decision to this form **or** briefly describe the decision below:
Summary of decision:

☐ Yes ☐ No 4. If you answered "No" to question 3, when was the MCO's Appeal and Grievance Committee decision due: .
(If possible, attach a copy of the MCO's letter that told you when you would receive a decision.)

Note: The MCO Appeal and Grievance Committee has up to 30 days to make a decision on your appeal. You must wait to see if the MCO sends you a decision on your appeal by the date in the letter before you can request a fair hearing.

SECTION D - REQUIRED

_____ _____
SIGNATURE – Member Date Signed

Mail or fax this form **AND** a copy of the MCO's appeal decision letter (or, if the MCO did not provide you with an appeal decision letter, the MCO's letter informing you of the date by which it would provide you with its decision) to:

Family Care Request for Fair Hearing
c/o Division of Hearings and Appeals
PO Box 7875
Madison WI 53707-7875
Fax: 608-264-9885

Your managed care organization:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please contact your care manager or a member rights specialist.