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| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**  Division of Medicaid Services Wis. Stats. § 46.287(2)(c)  F-00237 (01/2019) | | | | | | | |
| **appeal request – CARE WISCONSIN** | | | | | | | |
| Completing this form is voluntary. Personally identifiable information collected on this form is used to identify your case and process your request only. | | | | | | | |
| Name – Member | | | | | | Today’s Date | |
| Mailing Address | | | | | | | |
| City | | | State  WI | | | Zip Code | |
|  | | Check this box if you would like to appeal Care Wisconsin’s decision by requesting a meeting with the Care Wisconsin Grievance and Appeal Committee. | | | | | |
| **Continuing your services during an appeal of a reduction, suspension, or termination of a service**  If you are getting benefits and you ask for an appeal before your benefits change, you can keep getting the same benefits until a decision on your appeal has been made. If you want to keep your benefits during your appeal, your request must be postmarked or faxed ***on or before*** **the effective date of the intended action**. If the Grievance and Appeal Committee decides that Care Wisconsin’s decision was correct, you may need to repay the extra benefits that you got between the time you asked for your appeal and the time that the Grievance and Appeal Committee makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost.  **Check this box if you would like to request the same services to continue during your appeal.**  **Copy of your case file**  You have a right to a free copy of the information in your case file related to your appeal. Information means documents, records and other related material including any new or additional information Care Wisconsin gathers during your appeal.  **Check this box if you would like to receive the information in your case file from Care Wisconsin related to your appeal.** | | | | | | | |
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|  | **SIGNATURE** – Member | | |  | Date Signed | |  |
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| Mail or fax this form to:  Care Wisconsin  1617 Sherman Ave.  Madison WI 53704  Fax: 608-245-3821  To start your appeal as soon as possible, you can call Care Wisconsin at 608-245-3448 before mailing this form.  Your appeal must be postmarked or faxed no later than **60 calendar days** from the date on the Notice of Adverse Benefit Determination. | | | | | | | |
| Care Wisconsin:  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, call Care Wisconsin at 608-245-3448 or toll-free 800-963-0035, Monday through Friday, 8 a.m. to 4:30 p.m. TTY users should call WI Relay 711. | | | | | | | |