DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00236 (01/2019)

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

REQUEST FOR A STATE FAIR HEARING

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 Action	
Appeal related to: ☐ Eligibility ☐ Cost share ☐ Change to service/support ☐ Care plan		Briefly describe change to service/support:	

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

☐ Yes ☐ No 2. If you answered 'yes' to question one (1), did you request the same services to continue during your appeal with the MCO?

☐ Yes ☐ No 3. If you answered 'yes' to question one (1), have you appeared before the MCO's Grievance and Appeal Committee?

☐ Yes ☐ No 4. If you answered 'yes' to question three (3), have you received a decision from the MCO's Grievance and Appeal Committee? (Please attach a copy of the decision, if available.)

Continuing your services during an appeal of a reduction, suspension or termination of a service

If you are getting benefits and you ask for a fair hearing before your benefits change, you can keep getting the same benefits until a decision on your fair hearing has been made. If you want to keep your benefits during your fair hearing, your request must be postmarked or faxed ***on or before*** **the effective date of the intended action**. If the judge decides that your MCO's decision was right, you may need to repay the extra benefits that you got between the time you asked for your 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.

☐ **Check this box if you would like to request the same services to continue during your appeal.**

Copy of your case file

You have the right to a free copy of the information in your case file related to your grievance or appeal. Information means documents, records, and other related materials. This includes any new or additional information your MCO gathers during your appeal. To request copies contact your care manager or a member rights specialist.

_____ _____

SIGNATURE – Member Date Signed

Mail or fax this form **AND** a copy of the Notice of Adverse Benefit Determination or decision letter 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.