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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-00237 (01/2019) | **STATE OF WISCONSIN**Wis. Stats. § 46.287(2)(c) |
| **appeal request – Community Care, Inc/Community Care HEALTH Plan, Inc.****(HMO SNP) (Community Care)** |
| 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      | StateWI | Zip Code      |
| [ ]  Check this box if you would like to appeal Community Care, Inc.’s decision by requesting a meeting with the Community Care, Inc. Grievance and Appeal Committee. |
| **Continuing your services during an appeal of a reduction, suspension, or termination of a service****For Family Care and Partnership Members:**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 Community Care, Inc.’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 are a Family Care or Partnership member and if you would like to request the same services to continue during your appeal.****For Program of All-Inclusive Care for the Elderly (PACE) Members:**Community Care, Inc. will continue the current level of a **Medicaid** service until a decision on your appeal has been made if you request continuation ***on or before*** **the effective date of the intended action**. If the Grievance and Appeal Committee decides that Community Care, Inc.’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 are a PACE member and if you would like to request the same Medicaid services to continue during your appeal.** |
| **For All Programs**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 Community Care, Inc. gathers during your appeal.[ ]  **Check this box if you would like to receive the information in your case file from Community Care, Inc. related to your appeal.** |
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|  | **SIGNATURE** – Member |  | Date Signed |  |
| Mail or fax this form to: Community Care, Inc. 205 Bishops Way Brookfield WI 53005 Fax: 262-827-4044Your appeal must be postmarked or faxed no later than **60 calendar days** from the date on the Notice of Adverse Benefit Determination. |
| Community Care, Inc: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 Community Care, Inc. toll-free at 866-992-6600, Monday through Friday, 8 a.m. to 4:30 p.m. TTY users should call Wisconsin Relay at 711. |