REQUEST FOR STATE FAIR HEARING

Michigan Department of Health and Human Services
Michigan Administrative Hearing System
PO Box 30763
Lansing, MI 48909
Telephone Number: 800-648-3397 Fax: 517-763-0146

This form is for enrollees in a Managed Care Health Plan, MI Health Link* Plan, Community Mental Health Services Program (CMHSP)/Prepaid Inpatient Health Plan (PIHP), Healthy Kids Dental Health Plan or MI Choice Waiver Program

SECTION 1 – To be completed by the PERSON REQUESTING A STATE FAIR HEARING

Enrollee Name	Enrollee Telephone Number	Enrollee Social Security Number	
Address (No.& Street, Apt. No.)	City	State	Zip Code
Enrollee or Legal Guardian Signature	Enrollee Medicaid ID Number		Date Signed

☐ Managed Care Health Plan ☐ MI Health Link (*for Medicaid benefits only) ☐ CMHSP/PIHP
☐ Healthy Kids Dental health plan ☐ MI Choice Waiver

Name of Health Plan, CMHSP/PIHP or Waiver Agency that took the action: _____

Date of Notice of Appeal Decision (please include a copy of the notice): _____

☐ As of today's date, I have not received a Notice of Appeal Decision. I sent in an Internal Appeal on: _____

I am asking for a State Fair Hearing because: Use additional paper if needed.

_____

_____

_____

_____

Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing?

☐ **No**

☐ **Yes** (If yes, please explain here.) _____

SECTION 2 – Have you chosen someone to represent you at the hearing?

Has someone agreed to represent you at a hearing?

☐ **No**

☐ **Yes** (If Yes, have the representative complete and sign Section 3.)

SECTION 3 – Authorized Hearing Representative Information

Name of Representative (Please Print)	Representative Telephone Number	Relationship to Enrollee	
Address (No.& Street, Apt. No.)	City	State	Zip Code
Representative Signature	Date Signed		

SECTION 4 – To be completed by the AGENCY involved in the action being disputed by the enrollee

Name of AGENCY			AGENCY Contact Person Name
AGENCY Address (No.& Street, Apt. No.)			AGENCY Telephone Number
City	State	ZIP Code	State Program or Service being provided to Enrollee

This form is also available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Administrative Hearing System for the Department of Health and Human Services or www.michigan.gov/LARA >> MI Administrative Hearing System >> Benefit Services

REQUEST FOR STATE FAIR HEARING

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INSTRUCTIONS

A State Fair Hearing is an impartial review of a decision made by the Michigan Department of Health and Human Services, or one of its contract agencies, that an enrollee believes is wrong.

If you are enrolled in a Managed Care Health Plan, MI Health Link, CMHSP/PIHP, Healthy Kids Dental Health Plan or MI Choice Waiver program you MUST finish their internal appeal process before you can ask for a State Fair Hearing. If you do not receive a Notice of Appeal Decision within the mandated timeframe, you may also ask for a State Fair Hearing. You may also send in your signed hearing request in writing on any paper. This form is also available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Administrative Hearing System for the Department of Health and Human Services or www.michigan.gov/LARA >> MI Administrative Hearing System >> Benefit Services.

If you asked for your benefit(s) to continue during the internal appeal process and you want them to continue during the State Fair Hearing process, you must ask for the State Fair Hearing and the Michigan Administrative Hearing System (MAHS) must receive your request within 10 calendar days of the date on the Notice of Appeal Decision.

General Instructions:

- Read ALL instructions before completing the attached form.
- This form should not be used for a request for a hearing related to:
  - Public Assistance (Medicaid eligibility, cash assistance, food assistance, or other assistance programs). For these hearing types, you must use form DHS-18, Request for Hearing available online at http://www.michigan.gov/documents/FIA-Pub18_14356_7.pdf .
  - A decision that does not involve a managed care entity on a Medicaid service or your application for a MI Choice Waiver program. For these hearings types you must use form DCH-0092, Request for Hearing for Medicaid Enrollees or Waiver Applicants available online at: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Program Resources >> Michigan Administrative Hearing System for the Department of Health and Human Services or http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html.
- Please attach a copy of the Notice of Appeal Decision that you received from your managed care organization.
- Complete **Section 1** using the name of the enrollee (even if the enrollee has a guardian or is a minor).
- Complete **Section 2 and 3** only if you want someone to represent you at the hearing.
- Complete **Section 4** if the agency who took the action you are appealing did not fill this out.
- Please make a copy of this completed form for your records.
- If you have any questions, call: **517-335-7519 or** toll free at **800-648-3397**.
- After you complete this form, mail or fax (**no email**) to:

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
PO BOX 30763
LANSING MI 48909
Fax: 517-763-0146

- You may choose to have another person represent you at a hearing.
  - This person can be anyone you choose but he/she must be at least 18 years of age.
  - You MUST give this person written and signed permission to represent you.
  - You may give written permission by checking **Yes** in **Section 2 and having the person who is representing you complete Section 3**. **You MUST still complete and sign Section 1.**
  - Your guardian or conservator may represent you. **A copy of the court order naming the guardian must be included with this request or it cannot be processed.**

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	
If you do not understand this, call the Michigan Department of Health and Human Services at 877-833-0870. Si no entiende esta información comuníquese al Michigan Department of Health and Human Services al 877-833-0870. إذا كنت لا تفهم هذا، فعليك الاتصال بـ Michigan Department of Health and Human Services (وزارة الصحة والخدمات الإنسانية) على رقم الهاتف 877-833-0870.	**877-833-0870**
Completion: Is Voluntary	