FORM TO FILE A STATE HEARING FROM A DENTAL MANAGED CARE DENIAL

You can ask for a State Hearing by calling: **1-800-743-8525. TTD users, call 1-800-952-8349.**
You can also request a hearing in the following ways:

- You can request a hearing ONLINE at WWW.CDSS.CA.GOV
- You can fill out this form and **FAX** it to State hearings at **916-309-3487**
- You can fill out this form and **EMAIL** it to **SCOPEOFBENEFITS@DSS.CA.GOV**
- You can also **MAIL** this state hearing request to **:**

California Department of Social
ServicesState Hearings Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on the attached 'Your Rights' Notice

I do not agree with the decision about my dental care. State the treatment, drug, equipment, or service that the doctor requested. I disagree because:

_____
_____
_____
_____
_____
_____

(If you need more space, use another piece of paper and attach it to this one.)

PLEASE PROVIDE THIS INFORMATION ABOUT THE BENEFICIARY
(This is the person who was denied medical benefits)

NAME: _____

DATE OF BIRTH: _____

ADDRESS (Where you can get mail): _____

TELEPHONE NUMBER: _____

Do we have your permission to communicate with you by email? [☐] YES [☐] NO

If Yes, what is your **EMAIL ADDRESS:** _____

Please provide your **Medi-Cal BIC Card Number and /or Social Security Number** if you have one _____

Do you have Straight Medi-Cal (**Fee for Service**) or **Managed Care**? _____

If **Managed Care**, what is the **name of your HEALTH PLAN**: _____

PLEASE ANSWER EVERY QUESTION THAT APPLIES TO THE BENEFICIARY

My Dentist requested this health benefit on this date: _____

The Dental Plan denied this health benefit on this date: _____

I have appealed the case to the Dental Plan: YES [ ] **On what date**?_____NO [ ]

The Dental Plan gave an answer to the appeal: YES [ ] **On what Date?**_____NO [ ]

Did you ask the Dental Plan for an expedited (72 Hour) appeal? YES [ ] NO [ ]

Did the Dental Plan decide the appeal in 72 Hours? [ ] YES [ ] NO

I NEED THESE FOR MY HEARING (Check these Boxes if they apply to you):

☐ **I need an Expedited Hearing because my situation is urgent**. My case must be decided very quickly and I cannot wait for up to 90 days. This is what will happen without a quick decision:

_____
_____
_____

EXPLAIN WHY YOU CANNOT WAIT UP TO 90 DAYS. **If you do not explain, your case will not be expedited and will be scheduled** on the normal calendar. You can submit a letter from your doctor or plan to show why you cannot wait.

☐ **Continued Services / Aid Paid Pending: Please continue my treatment** until the Judge decides my case. (Describe the treatment that you want to continue and say **what date the plan stopped it** or **is planning to stop it**):

_____
_____

☐ **I want a Free Interpreter**. My language or dialect is: _____

☐ **I have a disability and want a reasonable accommodation to help me participate in my hearing**. The accommodation(s) I want is: _____
_____

☐ **I want someone else to speak for me (represent me) at the hearing.** She/he can see my dental records that relate to this hearing and come to the hearing. The person I have chosen to speak for me is:

Name:_____Phone Number: _____

Address: _____

My signature:_____Today's Date: _____

SEND THIS FORM WITH A COPY OF THE LETTER (NOTICE OF APPEAL RESOLUTION) YOU RECEIVED FROM YOUR PLAN IF YOU HAVE IT. (IF YOUWANT A COPY OF THIS FORM FOR YOURSELF, COPY IT BEFORE YOU SEND IT.)

The personal and medical information collected on and with this form is confidential, subject to the Department of Health Care Services (DHCS) Notice of Privacy Practices that can be found here: https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf. The Department of Social Services (CDSS) State Hearing Division needs the information in order to process your appeal and may share it with other agencies or contractors who assist in that process. DHCS and CDSS will not use or share the information for other purposes except with your permission or as permitted by law. You must provide all information requested on this form and provide the supporting documentation. If you do not provide all information requested, we cannot set a hearing or review the denial. In most cases, the individual(s) to whom this information pertains has the right to access it.

DHCS and CDSS are authorized to collect this information pursuant to Welfare and Institutions Code section 10950 et seq. and California Code of Regulations, title 22, section 50951 et seq. This privacy notice provided here is required by California Civil Code 1798.17.