FORM TO FILE A STATE HEARING FROM A MANAGED CARE DENIAL

You can ask for a State Hearing by calling: **1-800-743-8525**. **TDD 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 toll-free at **1-833-281-0903**
- You can fill out this form and **EMAIL** it to **SCOPEOFBENEFITS@DSS.CA.GOV**
- **(Note:** If you send it by email, *please understand there is a risk that someone other than the State Hearings Division could intercept your email. Please consider using a more secure method of sending your request.)*
- You can also **MAIL** this State Hearing Request **to:**
  California Department of Social Services
  State Hearings Division
  744 P Street, MS 9-17-433
  Sacramento, CA 95814

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 health 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 Doctor requested this health benefit on this date: _____

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

I have appealed the case to the Health Plan:
YES [ ] **On what date**? _____ NO [ ]

The Health Plan gave an answer to the appeal:
YES [ ] **On what Date?** _____ NO [ ]

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

Did the Health 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 medical 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 YOU WANT A COPY OF THIS FORM FOR YOURSELF, COPY IT BEFORE YOU SEND IT.)