

3 Copies:
1 AAO
1 Applicant or Beneficiary
1 Case File

<u>FOR DEPARTMENT USE ONLY</u>	
Case Name:	(Circle One) M / F
Sect/Unit/EW:	
Date Request Received:	Frm/Tel/Per/Mail/Other

REQUEST FOR A HEARING

I. I am requesting a hearing for the following reasons:

A. I DO NOT AGREE with the action taken by the Med-QUEST Unit/Office

- 1. My application was denied.
- 2. My redetermination for continued medical assistance was terminated.
- 3. Assessment of a spenddown, cost share, or enrollment fee.
- 4. Change in spenddown, cost share or enrollment fee amount.
- 5. Other (Specify) _____

Explain item(s) checked above: _____

(Continue on the back of this form if you need more space)

B. I DO NOT AGREE with the action taken by the managed care health plan.

- 1. My coverage or service was denied or terminated.
- 2. Other (Specify) _____

Explain item(s) checked above: _____

(Continue on the back of this form if you need more space)

II. A beneficiary may request for Aid Paid Pending and benefits may be restored while you wait for a hearing decision if:

- A. Item I-A was selected above and this form received by the Med-QUEST office within 15 calendar days from the date of the adverse notice.; or
- B. Item I-B was selected above and this form received by the Med-QUEST office within 10 calendar days from the date of the adverse notice; and
- C. Select one option below. *(If you do not make a selection, you will automatically receive Aid Paid Pending.)*

Yes. I want my benefits restored while waiting for a hearing decision and acknowledge that if the hearing decision is in favor of the Department or if I decide to withdraw or abandon my request for a hearing before a decision is made, I must repay all medical assistance or coverage I received for this period.

No. I do not want my benefits restored.

III. Optional Designation of Authorized Representative:

I give my permission to _____ to be my Authorized Representative
Print Name of Authorized Representative
to represent me and act for me in the Hearing.

(Print Claimant's Name) (Date)

(Claimant's Signature) (Date)

(Authorized Representative's Signature -Optional) (Date)

(Mailing Address)

(Mailing Address)