Local Appeal Request Form

SECTION 1: Appeal Request

☐ Oral Request Date: _____	☐ Written Request Date: _____
Local Appeal Request for ☐ Standard Resolution (5 days) or ☐ Expedited Resolution (3 days)	
Who is requesting Local Appeal: ☐ Beneficiary's ☐ Authorized Representative	

SECTION 2: Beneficiary Information

Beneficiary's Name		Home phone#	Work or Cell phone#	
Address (No. & Street, Apt#, etc.)		City	State	ZIP Code
Date of Birth	MH-WIN ID#:	Signature	Date Signed	
Provider Name:	Contact Person:	Provider phone#:	Date of Notice (if known)	

SECTION 3 - Have you chosen someone to assist or represent you with this request?

☐ YES (please fill-in information below)		**☐ NO**	
Name of Authorized Representative:		Home phone#	Work or Cell phone#
Address (No. & Street, Apt#, etc.)		City	State	ZIP Code
Representative Signature			Date Signed

SECTION 4 - Reason for Local Appeal Request

The following are my reason(s) for requesting a local Appeal. Use Additional Sheets if Needed.

I would like an opportunity to look at case/medical file or any records that will be considered during the Appeal?

☐ Yes ☐ No

I would like an opportunity to present information for review/consideration during the Appeal process?

☐ Yes ☐ No

Form completed by: _____ Date completed: _____

SECTION 4 - Reason for Local Appeal Request (continue)

INSTRUCTIONS FOR COMPLETION

SECTION 1 - Appeal Request
Check off if the request is filled out by beneficiary or authorized representative or if the form is being completed due to an oral request.

SECTION 2 - Beneficiary Information
Enter information about the beneficiary who is the requesting the local appeal, including the provider information.

SECTION 3 - Have you chosen someone to assist or represent you with this request?
Enter information that identifies the authorized representative - the beneficiary may chose someone to represent them or assist with the appeal process.

SECTION 4 - Reason for Local Appeal Request

Special Note:
The Beneficiary **must** continue to receive Medicaid services previously authorized while a Local Appeal and/or State Fair Hearing are pending **if**:

- The Beneficiary specifically requests to have the services continued, (Please contact provider to request services by calling Service Provider Pioneer Behavioral Health at 1-800-241-4949).
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of authorized treatment and services the beneficiary currently receives, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the Service Provider continues or reinstates the beneficiary's services while the appeal is pending, the service must be continued until one of the following occurs:

- The Beneficiary withdraws the request for a Local Appeal and/or State Fair Hearing.
- **Twelve calendar** days pass after the service provider mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached.
- A State Fair Hearing office issues a hearing decision adverse to the beneficiary.
- The time period or service limits of the previously authorized service has been met.

This form may be completed by the beneficiary, authorized representative, or any person including Agency, MCPN or CA staff person who is assisting the beneficiary with the Local Appeal process for Medicaid Beneficiaries.