Use this fair hearing request form (see reverse side of this form) if you are enrolled in one of MassHealth's contracted Managed Care Organizations, the Primary Care Clinician (PCC) Plan's Behavioral Health Program, or a Senior Care Organization (These will be referred to as "the Managed Care Contractor") and:

1. you disagree with the action by the Managed Care Contractor to deny, reduce, change, or stop a service;
2. you disagree with the action by the Managed Care Contractor to deny payment for a service (unless the denial is for a procedural reason, such as not following prior authorization or referral rules, or not filing a timely claim);
3. the Managed Care Contractor did not provide you with a service within the wait-time access standards described in your member handbook;
4. the Managed Care Contractor did not make a decision on your request to authorize a service within the service authorization time frames described in your member handbook; or
5. the Managed Care Contractor did not act on your internal appeal within the time frames described in your member handbook.

Also, if you are enrolled in a Managed Care Organization and you live in a rural service area (in Nantucket or Dukes counties only) that is served by only one managed-care organization, you can use this form if the managed-care organization denied your request to get services outside the managed-care organization's network.

Your Right to Appeal

If you disagree with the action by the Managed Care Contractor (listed in the box at the bottom of the fair hearing request form on the reverse side), you have the right to appeal and ask for a Fair hearing before an impartial hearing officer after you have gone through the Managed Care Contractor's internal appeal process, if it is required. If you are enrolled in a Senior Care Organization, you are not required to go through the internal appeal process.

Standard and Expedited Appeals

If your appeal followed standard appeal times during the Managed Care Contractor's internal appeal process, the Board of Hearings must get your fair hearing request form within 30 calendar days of the mailing date of the Managed Care Contractor's final written notice to you. If you are enrolled in a Senior Care Organization, the Board of Hearings must get your fair hearing request form within 30 calendar days of the mailing date of the Senior Care Organization's notice of appealable action.

If your appeal was expedited (reviewed quickly) during the Managed Care Contractor's internal appeal process, the Board of Hearings must get your fair hearing request form within 20 calendar days of the mailing date of the Managed Care Contractor's final written notice to you for your appeal to be expedited at the Board of Hearings. However, if the Board of Hearings gets your fair hearing request form between 21 and 30 calendar days of the mailing date of the Managed Care Contractor's final written notice to you, then the Board of Hearings will process your appeal using standard appeal times.

How to Appeal

To ask for a fair hearing, fill out this fair hearing request form (see reverse side of this form) and send one copy with a copy of the Managed Care Contractor's final written notice to: Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171 or fax them to 617-847-1204. Please keep one copy of the fair hearing request form for your information.

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Date of Fair Hearing

At least 10 calendar days before the Fair hearing, the Board of Hearings will send you a notice telling you the date, time, and place of the hearing. This will give you time to get ready for the hearing. If you want to have a Fair hearing scheduled as soon as possible, check Box B in Section III on the Fair hearing request form for an expedited hearing. If you have good cause for not being able to come to the hearing, or if you need a telephone hearing, you must call the Board of Hearings at 617-847-1200 or 1-800-655-0338 before the hearing date. If you do not reschedule or appear on time at the hearing without documented good cause, your appeal will be dismissed.

If you need an interpreter or an assistive device, please check either Box C or D, or both, in Section III on the Fair hearing request form if you need an interpreter or assistive device, or call the Board of Hearings at 617-847-1200 or 1-800-655-0338 at least five business days before the hearing.

Your Right to Review Your Records

You and/or your representative can review your records held by the Managed Care Contractor before the hearing. Your Managed Care Contractor will give you copies of the records at least five business days before your hearing or, if your appeal is expedited, within one business day after the Board of Hearings tells you and your Managed Care Contractor when the hearing will be. If you would like to see your records more quickly, you must schedule an appointment with the Managed Care Contractor before the Fair hearing. These records are not kept at the Board of Hearings. Call your Managed Care Contractor if you have any questions about your records.

If you need an interpreter or an assistive device, please check either Box C or D, or both, in Section III on the Fair hearing request form if you need an interpreter or assistive device, or call the Board of Hearings at 617-847-1200 or 1-800-655-0338 at least five business days before the hearing.
FAIR HEARING REQUEST FORM

SECTION I: Member Information

Name of Member: _______________________________________________________

Address: ________________________________________________________________

Telephone No.: (       ) ___________________________________________________

MassHealth I.D. or Social Security Number: ________________________________

Cardholder’s Name on MassHealth card (if different): ________________________

SECTION II: Reason for Appeal (Check the box that applies to you.)

☐ I am enrolled in a Managed Care Organization or the Primary Care Clinician Plan’s Behavioral Health Program and I am appealing the action or inaction of the Managed Care Contractor (listed in the box at the bottom of this form) taken on (please put date of written notice): ___________________________.

By checking this box, I am certifying that I have gone through the Managed Care Contractor’s internal appeal process. (Please remember to send a copy of the Managed Care Contractor’s final written notice to you with this form.)

☐ I am an enrollee of a Senior Care Organization and I am appealing a decision of the Senior Care Organization. (Please remember to send with this form a copy of the Senior Care Organization’s final written notice to you and any other notices that the Senior Care Organization sent you during the internal appeal process (if you chose to file an internal appeal).

☐ Other: I want a fair hearing because: ______________________________________

______________________________________

Signature: ___________________________ Date: ___________________________

SECTION III: Appeal Information (Check the boxes that apply to you.)

☐ A. I do not want to keep getting the requested service during the appeal process.

☐ B. I want an expedited hearing.

☐ C. I need an interpreter (what language?): ____________________________ to be provided by the Board of Hearings.

☐ D. I need an assistive device to be provided by the Board of Hearings.

(Describe what type of assistive device you need. For example: American Sign Language): __________________________________________

SECTION IV: Appeal Representative, if any

My appeal representative is: _____________________________________________

Title: _________________________________________________

Address: ________________________________________________

Telephone No.: (       ) ________________________________

FOR MCO-PCCBH-SCO USE ONLY

Managed Care Contractor: _________________________________

Telephone No.: _______________________________________

Date of Action: ________________________________________