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COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID
BOARD OF HEARINGS

FAIR HEARING REQUEST FORM

See instructions on back for instructions on how to ask for a fair hearing.

First Name: Middle Initial: Last Name:

Mailing Address:

City: State: Zip:

Phone Number: Member ID: Date of Birth:

REASON FOR YOUR APPEAL (Check any reasons that apply.)

☐ Income ☐ Citizenship or immigration status ☐ Access to other insurance ☐ Family size ☐ Residency ☐ Incarceration status
☐ Other _____

WHY ARE YOU APPEALING?

Attach any documents that support your reason.

OTHER INFORMATION (Check all that apply.)

☐ During the appeal process, I want to keep the benefits that I was receiving before. If I check this line and lose my appeal, I may have to pay back the cost of the benefits I received during my appeal.

☐ During the appeal process, I accept the proposed change in my benefits. If I check this line and win my appeal, MassHealth will restore my original level of benefits.

☐ I choose prehearing resolution (PHR). PHR is available for eligibility decisions only. See reverse for more details.

TYPE OF HEARING AND ACCOMMODATIONS (Check all that apply.)

I want my hearing to be held

☐ In person
☐ By phone. My phone number is _____ .
☐ By video. My email is: _____ .

☐ I need an interpreter. My language is _____ (MassHealth will provide the interpreter for the hearing at no cost.)

☐ I need an assistive device to communicate at a hearing. Describe the type of device you need. We will provide an assistive device for the hearing.

☐ I need another accommodation for a disability. Describe the accommodation you need.

NAME OF APPEAL REPRESENTATIVE, IF YOU HAVE ONE

Appeal Representative Name: Phone number:

Mailing Address:

City: State: Zip:

SIGNATURE

The information on this form is true and accurate, to the best of my knowledge. For the purpose of this appeal, I authorize MassHealth to provide me and my representative, if I have one, with my individual information, including federal and state tax information used to determine my eligibility.

Signature: Date:

First & Last Name (Print):

If this is signed by someone other than an appellant 18 years of age or older who has authority to file, attach a copy of your authority to file the appeal on behalf of the appellant. Examples include a copy of your power of attorney document or evidence of court appointment as a personal representative.

HOW TO ASK FOR A FAIR HEARING

Your Right to Appeal: You have the right to ask for a hearing before an impartial hearing officer and to appeal an action taken by MassHealth in the following cases:

1. You disagree with an action taken by MassHealth, or
2. Mass-Health did not act on your request in a reasonable time.

How to Appeal: You may file an appeal in any of the following ways:

- Filling out this hearing request form and sending it with a copy of the notice you are appealing to

  The Board of Hearings
  Office of Medicaid
  100 Hancock Street, 6th floor
  Quincy, MA 02171
- Faxing or efaxing these materials to the Board of Hearings at **(617) 887-8797**.
- Calling the MassHealth Customer Service Center at **(800) 841-2900**, **TDD/TTY: 711**, to fill out your request for a fair hearing form b**y phone.**

Questions: If you have a question about your hearing, contact the Board of Hearings at (617) 847-1200 or (800) 655-0338.

Time Restrictions: The Board of Hearings must receive your completed, signed request within 60 calendar days from the date you received the notice of our action. If you did not receive a written notice of the action, or if MassHealth did not take an action on your application, you must file your request no later than 120 calendar days from the date the action takes place or the date of the application.

Prehearing Resolution (PHR): This option is for eligibility appeals only. You may choose this option if you would like to resolve a matter before holding a formal fair hearing. If you select a PHR, MassHealth will contact you. In some situations, the Board of Hearings may schedule you before MassHealth contacts you. You may select a PHR to resolve eligibility-related matters such as incorrect contact information, submission of missing documents or renewal, explanation of income verification, or an eligibility decision. The PHR option is not for non-eligibility related decisions.

Fair Hearing: If a matter cannot be resolved by prehearing resolution, you will continue to a full hearing scheduled by the Board of Hearings. A hearing officer will decide if the actions taken by MassHealth were appropriate. You will then be notified of that decision.

Expedited Hearing: In limited cases, an expedited hearing may be provided. The Board of Hearings will automatically schedule an expedited hearing when needed.

If You are Now Getting MassHealth Benefits: You may be eligible to keep your benefits between the time you appeal and the time that the Board of Hearings makes a decision to approve or deny your appeal. If you decide to keep your benefits while the appeal is pending, and then you lose your appeal, you may have to pay back the cost of the benefits you received. If you do not get benefits, and then you win your appeal, MassHealth will restore your benefits. You will keep your benefits if the hearing form is received either before the benefits stop or within 10 calendar days from the date you receive the MassHealth notice, whichever is later. Please mark your choice in the Other Information section of the form.

Date of Fair Hearing: At least 10 days before the hearing, the Board of Hearings will send you a notice telling you the date, time, and place of the hearing. Your hearing may be conducted by phone. You can ask us to reschedule a hearing, but you must have good cause. If you do not reschedule or appear on time to the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing: At the hearing, you may have a lawyer or other person represent you, or you may represent yourself. MassHealth will not pay for anyone to represent you. You may contact a local legal aid service or community agency to see if you can receive advice or representation at no cost. A hearing request can also be filed on your behalf by a person authorized to act on your behalf. If someone other than a lawyer is acting on your behalf, please attach a copy of any documents authorizing that person to do so, such as power of attorney, guardian, or invoked health care proxy.

If You Need an Interpreter, Assistive Device, or Other Accommodation: If you do not understand English or if you are hearing or sight impaired, MassHealth will provide an interpreter or assistive device at the hearing at no cost to you. We will also make other reasonable accommodations that a person with a disability may need to participate in the hearing. Please tell us what you need in the Type of Hearing and Accommodations section of the form.

Your Right to Review Your Case File: You or your representative can review your case file before the hearing. If you wish to review your case file, call the MassHealth Customer Service Center at **(800) 841-2900**, **TDD/TTY: 711**.

Your Right to Ask to Subpoena Witnesses and Your Right to Question: You or your representative may write the Board of Hearings to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and ask questions of witnesses at the hearing. The hearing officer will make a decision based on all evidence presented at the hearing.

Impact on Other Household Members: An appeal decision for one household member may change eligibility for other household members. If that happens, affected household members will receive a new eligibility notice explaining the changes.