

Michelle Lujan Grisham, Governor

Kari Armijo, Secretary Alex Castillo Smith, Deputy Secretary Kathy Slater Huff, Deputy Secretary Kyra Ochoa, Deputy Secretary Dana Flannery, Medicaid Director

Fair Hearing Request

Please complete and submit this form to the Office of Fair Hearings at HCA-FairHearings@hca.nm.gov or 505-476-6215 (fax).

Section A - Claimant Information	Section B – Representative Information		
	☐ Check this box if you have a representative. Complete the		
First Name MI	information below		
Last Name Suffix	First Name Last Name		
Mailing address	Agency Name		
	Mailing Address		
City State Zip Code	City Code		
Case Number	City State Zip Code		
	Phone or message number		
If known, please list the name of the agency issuing the adverse action (i.e. ISD, Presbyterian, Blue Cross, United, Molina,			
Comagine, DDSD, CSSD, etc.) and the date of the notice. If available, please include a copy of the notice of adverse action	Relationship to Claimant (enter if the representative is an Attorney, Legal Guardian, POA, Authorized Representative,		
that was sent to you.	etc.) Documentation authorizing representation must be submitted along with this form.		
Section C - Appeal Information			
I am requesting a Fair Hearing for the following program(s):			
☐ SNAP ☐ Temporary Assistance for Needy Families (TANF) ☐ LIHEAP/LIHWAP			
☐Child Support Services ☐ General Assistance ☐Medicaid ☐Managed Care Organization (MCO) ☐DD/MiVia Waiver ☐Nursing Facility Discharge/Admission & PASARR ☐Medicaid Estate Recovery			
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Issue(s) to be heard:			
☐ Closure ☐ Denial ☐ Reduction ☐ Delay ☐ Res☐ Child Support Enforcement (i.e. tax intercept, bank lier☐ MCO Enrollment ☐ MCO Services (i.e. med	n, etc.) DD/MiVia Services (i.e. budget, therapy, etc.)		
If the issue involves an MCO, has the MCO's internal appeal process been completed?: $\Box \mathbf{Yes} \Box \mathbf{No}$			

PLEASE COMPLETE SECTIONS "D", "E" AND "F" ON THE NEXT PAGE



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Section D – Reason for Hearing			
Please provide a description below as to why a Fair Hearing is needed and why the action(s) taken is incorrect. Please			
provide as much detail as you can.			
Section E – Continuation of Benefits			
Section E - Continuation of Benefits			
Please Select from one of the choices below:			
☐ If receiving benefits, I want to continue receiving the same amount of benefits while I wait for a <i>Final Decision</i> .			
I understand I may be responsible for repayment of benefits issued to me if the <i>Final Decision</i> is not in my favor.			
☐ I do not want to continue receiving the same amount of benefits while I wait for my <i>Final Decision</i> .			
Section F - Signature			
Claimant or Authorized Representative Signature:	Date:	Telephone Number:	
		-	

You may contact the NM State Bar Association at 505-797-6000 for available legal resources.

Any evidence you wish to present at your Fair Hearing can be emailed to <u>HCA-FairHearings@hca.nm.gov</u> or faxed to 505-476-6215.