louisiana healthcare connections

Request for State Fair Hearing

Member Name: ____________________

Member Medicaid #: ____________________

Member Address: ____________________

City: __________ State: ______ Zip: ______

Member Phone: ____________________

I wish to appeal the decision made by Louisiana Healthcare Connections on my case because:

____

____

Member Signature: ____________________ Date: __________

Authorized Representative Information

If the member has authorized a representative to request a State Fair Hearing, please complete this section.

Representative Name: ____________________

Representative Social Security #: ____________________

Representative Address: ____________________

City: __________ State: ______ Zip: ______

Representative Phone: ____________________

Representative Signature: ____________________ Date: __________

MAIL THIS FORM AND YOUR NOTICE OF ADVERSE ACTION LETTER TO:

Division of Administrative Law—Health and Hospitals Section
P.O. Box 4189, Baton Rouge, LA 70821-4189
Or fax to: (225) 219-9823

The postmark when you mail this form will be the date of your Appeal request. After you ask for a State Fair Hearing, the Division of Administrative Law will send you a Notice by mail of the date, time and location of your State Fair Hearing. If you are unable to mail or fax the attached form, you can request a State Fair Hearing by calling (225) 342-5800 or going to: www.adminlaw.state.la.us/HH.htm.

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