State Fair Hearing Request Form

Medi-Cal Rx

Your Right to a State Fair Hearing

If you disagree with the action being taken regarding either new or continuing services on this notice, you have the right to ask for a State Fair Hearing **within 90 days** from the date this notice was mailed or given to you (Welfare and Institutions Code Section 10951). After 90 days and up to 180 days, the judge may decide if there is good cause for a late filing. Although requesting a State Fair Hearing is within your rights, no action may be necessary if this notice is for a deferred service that is waiting for a response from your provider.

If this request is for a **continuation of a service you are already receiving**, you **may** be allowed to continue to receive the service until the judge decides your case. This is called **aid paid pending**. To be considered for aid paid pending, you must ask for a State Fair Hearing **within 10 days** of the date of this notice, **or before** the date the notice says your service will end, whichever comes later. If you ask for a hearing within these timeframes, your service may continue until the judge's decision is issued. If you later withdraw your hearing request, your service will continue until previously approved service dates expire (California Code of Regulations, Title 22, Section 51014.2).

This notice does not affect your eligibility for Medi-Cal. You will continue to receive your Medi-Cal benefits and the covered Medi-Cal services for which you have been approved.

To request a State Fair Hearing:

- **Submit** the attached State Fair Hearing Request Form
- **Call** the State Hearings Division at 1-800-743-8525 (TTY users, call 1-800-952-8349)

OR

- **Write** to

  California Department of Social Services
  State Hearings Division
  PO Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  - Please Include
    - Name of Medi-Cal Beneficiary
    - Medi-Cal Beneficiary Identification Card (BIC) number
    - Address
    - Phone number
    - Reason for requesting a State Fair Hearing
    - Language or dialect (in case you need an interpreter)

- Name, address, and telephone number of the person, if any, you will bring with you to the hearing to help you
- Any accommodations needed to help you fully participate in the hearing

OR

- **Go online** at www.cdss.ca.gov/hearing-requests

OR

- **Fax** the attached State Fair Hearing Request Form to 833-281-0905

OR

- **Email** the attached State Fair Hearing Request Form to scopeofbenefits@cdss.ca.gov

If you want to know more about your state hearing rights, call the Public Inquiry and Response Unit at 1-800-952-5253. If you have trouble hearing or speaking, use TTY at 1-800-952-8349.

- You can represent yourself or you can bring a friend, relative, attorney, or any other person to help you at your hearing. You must provide their name, address, and phone number to the State Hearings Division and indicate you want them to represent you.
- If you have a disability or impairment and need special arrangements so you can participate in your hearing, call State Hearings Division toll free at 1-800-743-8525. If you have a hearing or speech impairment, call (TTY) 1-800-952-8349.
- You may be able to get free legal help. Look for "Legal Services" in the Community Services section of your local Yellow Pages. Or you can contact the State Bar of California at 866-44-CA-LAW (866-442-2529) or visit its website at http://www.calbar.ca.gov/Public/Free-Legal-Information/Legal-Guides/Lawyer-Referral-Service.
- If you request a hearing, please refer to the Department of Health Care Services' position statement for information that was used to make this decision. The position statement will be sent to you not less than two working days prior to the date of your hearing.
- The state fair hearing process is separate from the process for reporting discrimination complaints. If you wish to learn more about reporting a discrimination complaint, please contact the Department of Health Care Services' Office of Civil Rights at

PO Box 997413, Mail Station 0009

Sacramento, CA 95899-7413

(916) 440-7370, 711 (California State Relay)

Email: CivilRights@dhcs.ca.gov

State Fair Hearing Request Form

Your Name: _____

Medi-Cal ID (BIC) Number: _____

Your Address: _____

_____

Prior Authorization Control Number and Service Description: _____

_____

You can request a hearing by **calling** 1-800-743-8525 (TTY users, call 1-800-952-8349) or by **mailing** this form to the California Department of Social Services, State Hearings Division, PO Box 944243, Mail Station 9-17-37, Sacramento, CA 94244-2430.

You can also request a hearing **online** at www.cdss.ca.gov, by **faxing** this form to 833-281-0905, or by **emailing** the form to scopeofbenefits@cdss.ca.gov.

For free help filling out this form, call the State Bar of California's legal help at 866-44-CA-LAW (866-442-2529).

Reason for Requesting the Hearing

Name of Beneficiary: _____

Date of Birth: _____

Mailing Address: _____

_____

Phone Number: _____

Medi-Cal ID (BIC) and/or Social Security Number (if available): _____

I do not agree with the Medi-Cal decision. The drug, service, equipment, or treatment my doctor requested is _____

I disagree because _____

_____

_____

_____

_____

(If you need more space, use another piece of paper and attach it to this form.)

I need these for my hearing

Check these boxes *only* if they apply to you.

☐ I need an Expedited Hearing because my situation is urgent, and I cannot wait for up to 90 days. (You *must* explain why you need a quick hearing, or it will be denied).

_____

_____

_____

☐ Aid Paid Pending: Please continue my treatment until the judge decides my case. (Describe the treatment to be continued and say what date Medi-Cal stopped it or is planning to stop it).

_____

_____

_____

☐ I want a Free Interpreter. My language or dialect is _____

☐ I have a disability and want a reasonable accommodation to help me participate in my hearing. The accommodation(s) I want is _____

☐ I want someone else to speak for me (represent me) at the hearing. That person is

Name: _____

Address: _____

Phone Number: _____

Signature: _____

Today's Date: _____

If you want a copy of this form for yourself, copy it before sending.