Member Request for an AHCCCS/ALTCS Appeal Fair Hearing

AHCCCS/ALTCS Member Information:

Member Name: _____ AHCCCS ID #: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Phone: _____

Information about Person Filing Appeal (if different from above):

Name: _____ Phone: _____
Address: _____ Relationship to Member: _ Parent _ Guardian
City, State, Zip: _____ _ Other _____

Information about Fair Hearing Request:

I filed my appeal on: _____ (date) Appeal No.: _____

My health plan denied my appeal on: _____ (date)
(request for fair hearing must be filed withing 30 days of the health plan decision to deny the appeal)

I would like a fair hearing because: _____
_____
_____
_____
_____
(Please use back of form or attach additional sheets if you need more room.)

Continuation of Services During Appeals Process
I would like my services continued during the appeal: _ Yes _ No
**To continue services, appeal must be (1) filed within 10 days of decision & (2) involve existing or current services

Expedited Fair Hearing
I am requesting an expedited fair hearing: _ Yes _ No
**AHCCCS must expedite the appeal & issue a decision in 3 working days if it is determined that the time of a regular hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
Recommended: provide supporting documentation from member's doctor about need for expedited appeal.

Signature: _____ Date: _____
_ AHCCCS/ALTCS Member _ Guardian _ Parent _ Other _____
**If form is signed by someone other than member or parent of child under 18, please attach your written authority to act on behalf of the member (i.e. Letters of Guardianship, Designation of Representative).

Appeal Filed with: Grievance and Appeals Coordinator
Health Plan: _____
Address: _____
City, State, Zip _____

Appeal Filed by: _ Certified Mail or fax (NO. _____) (recommended)
_ US Mail _ Hand Delivered

Make sure to keep a copy of this completed form for your records!