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| --- | --- | --- | --- | --- |
| **DATE OF NOTICE:** | **EFFECTIVE DATE OF ACTION:** | | | **ID#** |
| **BENEFICIARY’S NAME:** | |  | | |
| **DOB:** | | **MEDICAID:**  Y  N | | **MEDICAID#:** |
| **If you are not the beneficiary, what is the relationship *(e.g.: guardian, parent of a minor child, POA, provider, representative, other):*** | | **Is the guardian or legal representative aware of this appeal and wishes to proceed?**   Y  N  N/A | | |
| **BENEFICIARY:**  name: ￼  Mailing Address:  Alt Phone: | |  | | |
| **WHY ARE YOU REQUESTING A LOCAL APPEAL?** | | | | |
| **SERVICE(S): Please provide any documentation you have regarding this appeal (ie: letters from doctors, supports coordinator, etc.)** | | | | |
| **PROVIDER AND CONTACT INFORMATION:** | | | **DO YOU REQUEST THE** **SERVICE(S) TO CONTINUE?**  Y  N  N/A | |

**Signature of Individual or Parent/Guardian/Representative** **Date**

**Please attach a copy of the Notice of Adverse Benefit Determination to this request.**