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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.**