REQUESTING A FAIR HEARING

- **If you disagree with LIBERTY's denial, reduction, suspension, or termination of service, you may request a Fair Hearing.** A Fair Hearing allows you and **LIBERTY** to give information about your situation to a Hearing Officer. The Hearing Officer is a neutral party who makes a decision on your appeal. There is no charge for a Fair Hearing.

- **Medicaid must receive your request within 120 calendar days from the Notice Date.**

- **You may represent yourself or have the help of another adult.** The adult can be a friend, family member, or lawyer. Medicaid has provided the names of some agencies that may be able to help you. (See below).

- **The request for a Fair Hearing must include:** (1) your name, address, telephone number, (2) Medicaid number; and (3) if someone is helping you, the name, telephone number and address of the adult who will help you (the "authorized representative"). You must sign the request unless you are unable to do so because of your disability. You may use the enclosed form to request a Fair Hearing.

- **If you want your services to stay the same during Fair Hearing process, you must: 1) ask for a hearing not more than 10 calendar days after the Date of Action (shown on the Notice of Decision); and 2) you must ask that your services stay the same.** (During the Fair Hearing process, your services will be continued) You may use the enclosed form to do this.

- **LIBERTY may ask you to pay back the cost of the continued services if you lose your appeal.**

- **After you have requested a Fair Hearing, Medicaid will contact you within 10 days to arrange a Hearing Preparation Meeting (HPM).** The meeting will be by telephone. The goal of this meeting is to try to resolve your appeal. **LIBERTY** will explain its decision and give you the chance to provide more information. If you and **LIBERTY** cannot agree, you may go to a Fair Hearing. **A Hearing Preparation Meeting (HPM) is optional.** You do not have to take part in a HPM. You can let Medicaid know you want to go directly to a Fair Hearing and have a Hearing Officer decide your appeal.

To find out more about Medicaid appeals, you may go to the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy's Medicaid Service Manual Chapter 3100 — Hearings at: https://dhcfp.nv.gov

If you cannot afford legal counsel, one of the Legal Services programs listed below may be able to help.

Nevada Legal Services, Inc. (Reno) (Washoe County): (775) 284-3491

Nevada Legal Services, Inc. (Las Vegas) Clark, Lincoln, Nye, and Esmeralda Counties: (702) 386-0404 or (866) 432-0404 TDD: (702) 386-1059

Nevada Legal Services, Inc. (Elko) Elko County: (775) 753-5880

Nevada Legal Services, Inc (Carson City) Carson City and remaining counties: (775) 883-0404 or (800) 323-8666

Senior Law Project (Las Vegas) Clark County residents age 60 and older: (702) 229-6596 TDD: (702) 386-9108

Washoe County Senior Law Project Washoe County residents age 60 and older: (775) 328-2592

Nevada Disability Advocacy and Law Center (South) Disabled Persons and Families with Disabled Persons: (702) 257-8150 or (888) 349-3843, TTY: (702) 257-8160

Nevada Disability Advocacy and Law Center (North): (775) 333-7878 or (800) 992-5715 or TTY: (775) 788-7824

FAIR HEARING REQUEST FORM

I am submitting this form to request a Fair Hearing. (Check all that apply and complete fields below)

☐ I disagree with **LIBERTY's** decision to reduce, terminate or deny benefits.

☐ I am requesting my Fair Hearing be expedited because a standard hearing could jeopardize my life, health or ability to attain, maintain or regain maximum function. The documentation from my medical provider to support this request is attached. (If you do not supply this documentation, this request will be processed within the Standard Fair Hearing timeframe, 90 days.)

☐ I am requesting a fair hearing based on the issue of reasonable promptness.

☐ During the Fair Hearing process, I would like my benefits continued. I understand I may have to pay back the cost of services or items if I do not win the Fair Hearing.

☐ Please send me a free copy of the regulations relevant to my case. Also available at website: http://dhcfp.nv.gov/.

Recipient name:_____ Phone: _____

Recipient mailing address:_____

Recipient ID number: _____

Recipient signature:_____ Date: _____

Authorized representative name:_____Phone: _____

Representative mailing address: _____

Authorized representative signature:_____ Date: _____

Estoy entregando esta forma para pedir una Audiencia Justa: (Chequee todos los que aplican y complete las lineas de abajo)

☐ Yo no estoy de acuerdo con la decision de LIBERTY de reducir, terminar o negar beneficios.

☐ Estoy solicitando que mi audiencia imparcial sea acelerada porque una audiencia estándar podría poner en peligro mi vida, mi salud o mi habilidad para alcanzar, mantener o recuperar la máxima función. La documentación de mi proveedor médico para apoyar esta solicitud se adjunta. (Si no suministra esta documentación, esta solicitud se procesará dentro del plazo estándar de audiencia imparcial, 90 día.)

☐ Yo estoy pidiendo una Audiencia Justa basado en el asunto de tiempo razonable.

☐ Durante el proceso de Fair Hearing, yo quisiera que mis beneficios continúen. Yo entiendo que yo podria tener que pagar los costos por servicios o cosas, si yo no gano la Audiencia Justa.

☐ Por favor mándeme una copia gratis de las regulaciones relevantes a mi caso. También disponibles en la pagina del internet http://dhcfp.nv.gov/.

Nombre del Recipiente: _____ Teléfono: _____

Dirección del Recipiente: _____

de ID del recipiente: _____

Firma Del Recipiente:_____ Fecha: _____

Nombre del Representante Autorizado:_____Teléfono: _____

Dirección del representante: _____

Firma del representante autorizado:_____ Fecha: _____

Return this request to/ Regrese esta petición a:
Nevada Medicaid Hearings Unit
1100 East William Street – Suite 101
Carson City, NV 89701
Fax # (775) 684-3610, E-Mail dhcfphearings@dhcfp.nv.gov