Washington State Department of Social & Health Services
MSA Management Services Administration

REQUEST FOR HEARING

per Chapter 388-02 for DSHS hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME | TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION | DATE

MAIL TO: OFFICE OF ADMINISTRATIVE HEARING (OAH)
PO BOX 42489
OLYMPIA WA 98504-2489

MAIL STOP: 42489

FAX: 360-586-6563

If you are requesting a hearing for the denial of medical benefits or services from your DSHS managed care health plan, you <u>must</u> complete your plan's appeal process <u>before</u> you can file a hearing. (WAC 388-538-112)

I request a hearing because I disagree with the following decision by the Department of Social and Health Services (DSHS) or my DSHS managed care health plan:

- Explain briefly what DSHS or your DSHS managed care health plan did or did not do (add pages if you need more room); and
- Attach a copy of the notice you are appealing, if possible.

YOUR NAME (PLEASE PRINT)	DATE OF BIRTH
MAILING ADDRESS OF PERSON REQUESTING HEARING CITY STATE ZIP CODE	CLIENT ID NUMBER TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ MESSAGE PHONE

I was notified of the decision on: _____ by: _____
DATE | CSO OR DSHS MANAGED CARE HEALTH PLAN NAME AND LOCATION

I want continued assistance, if I am eligible: ☐ Yes ☐ No Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER
ADDRESS STREET	CITY STATE	ZIP CODE

☐ **I authorize release of information about my hearing to the representative listed above.**

YOUR SIGNATURE	DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ Yes ☐ No

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing. Follow the instructions in the Notice of Hearing that will be mailed to you by OAH.