|  |  |
| --- | --- |
| **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) MAIL STOP: 42489 PO BOX 42489 OLYMPIA WA 98504-2489 **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 must complete your plan’s appeal process before 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:1. Explain briefly what DSHS or your DSHS managed care health plan did or did not do (add pages if you need more room); and
2. Attach a copy of the notice you are appealing, if possible.
 |

|  |
| --- |
|  |

|  |
| --- |
|  |
| YOUR NAME (PLEASE PRINT) | DATE OF BIRTH |
| MAILING ADDRESS OF PERSON REQUESTING HEARINGCITY STATE ZIP CODE | CLIENT ID NUMBERTELEPHONE 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 [ ]  NoProgram:   |
|  |
| 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 [ ]  NoIf 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. |