HOW TO ASK FOR A HEARING

You have the right to apply for a hearing if:

- You were denied a service by Kentucky Medicaid
- You have been placed in Lock-In

A hearing gives you a chance to explain your situation to a hearing officer. The hearing officer decides if Kentucky Medicaid has made the right decision.

Denied Services:

If you did not receive a Medicaid service you think you were eligible for, call the Member Services team at 800-635-2570. We will look at your record and help you understand why you did not get the service. We must provide written notice to you whenever Medicaid stops, reduces, or suspends Medicaid eligibility or covered services.

If you still think that you should get a service after you talk to us, you can ask for a hearing. To ask for a hearing, you need to write a letter to the Kentucky Department for Medicaid Services. You or your provider can appeal this decision. You can also have someone else act on your behalf. This person is called your authorized representative. Please tell us, in writing, who your authorized representative is before he or she acts for you. This person may be:

- Your guardian
- Relative
- Friend
- A Lawyer
- Another person of your choice

If you are being denied a service that you are getting now**, you must mail your written request within 10 days of getting your denial notice to keep receiving the Medicaid service**. If you do not need to keep your service, you have up to 30 days of getting your denial letter to mail in a written request for a hearing. The Kentucky Department for Medicaid Services will only take written requests. If you ask for a hearing on time, you will keep your benefits (except for EPSDT Special Services) through the hearing process.

Continuation of Benefits While We Review an Appeal

You may ask that your benefits continue while your appeal is in review. To do this, all of the following must be met:

1. The member asks to extend benefits
2. The appeal request is filed within 10 days of the date on the denial letter
3. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
4. The services were ordered by an authorized provider
5. The coverage period previously authorized has not expired

You may have to pay the cost of services if the first decision is not changed.

If you are being denied a new service, you will not be able to get the service until the hearing is completed.

You will get a written notice of the hearing date. The notice will tell you what time the hearing is and where to go. The hearing will be close to your house. If you want to have the hearing on the phone, you can ask for that. The hearing date should be no more than 30 days from the date of your letter asking for a hearing. Before the hearing, you have the right to examine your case file and any documents or records that will be used at the hearing by the Kentucky Department for Medicaid Services, by making an open records request.

Go to the hearing. If you don't go, your case will be dismissed. At the hearing you will explain your problem to the hearing officer and you can say why you should get that service. You can bring a friend or a lawyer with you and any witnesses you believe may be helpful. Medicaid may have a lawyer at the hearing also.

The hearing officer will mail you his recommended decision within 60 days of the date of your signature on the letter asking for a hearing. You can file written notice to Medicaid within 15 days of the decision. Medicaid will make a final decision within 90 days of the hearing officer's recommended decision. If you still feel that the decision is wrong, you can appeal to the Circuit Court. You have 30 days from the date of the final order to make that appeal.

Sample Hearing Request Letter

(Date)

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality and Outcomes
275 East Main Street, 6C-C
Frankfort, Kentucky 40621-0001

Attn: Hearing Request

Dear Sir or Madame:

I am writing to ask for a hearing.

My Medicaid ID Number is _____.

My Social Security Number is _____.

My address is _____.

My telephone number is _____.

(Below write the reason you are requesting a hearing.)

_____

_____

_____

_____

_____

Thank you.

Sincerely,

(Sign Your Name) _____