**Date: [Date Notice is Mailed]**

To ask for a State Fair Hearing and External Medical Review, you can call Driscoll Health Plan at 1-877-324-7543, email: [DHP\_QM\_Appeals@dchstx.org](mailto:DHP_QM_Appeals@dchstx.org), or complete this form and mail or fax it to us:

***Please return this form to*:**

Driscoll Health Plan

Quality Management Department

Attn: Member Appeals Team

4525 Ayers Street

Corpus Christi, Texas 78415

Fax Number: 361-808-2186

**You must request a State Fair Hearing by [120 days from date notice is mailed].**

If you kept receiving services during your health plan appeal, you may be able to keep getting your services during your State Fair Hearing. Make your request by **[date must be the later of the following- 10 days from the date this notices is mailed, or the date services will change]** only if you kept services during your health plan appeal.

**Mark the State Fair Hearing option you want:**

*Select only one*

State Fair Hearing

State Fair Hearing and External Medical Review

Emergency State Fair Hearing\*

Emergency State Fair Hearing and Emergency External Medical Review\*

\*Emergency State Fair Hearings and Emergency External Medical Reviews should only be requested if you believe your health will be seriously harmed by waiting for your State Fair Hearing or External Medical Review decisions.

Denial Reference Number: [Reference Number]

**Do you want your services to continue?**  Yes No

Your services can only be continued if they were also continued during your Health Plan Appeal. If you want your services to continue, you must request a State Fair Hearing and ask to keep your services by [**date must be the later of the following- 10 days from the date this notices is mailed, or the date services will change].**

You can make this request by phone. Please call Driscoll Health Plan at 1-877-324-7543 if you believe this form will not reach us by mail before the deadline.

**Personal Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | **Date of Birth:** |  |
| **Member ID:** |  | | | **Subscriber Number:** |  |
| **Address:** |  | | | **City:** |  |
| **State:** |  | | | **Zip Code:** |  |
| **Preferred Phone #:** | |  | | **Alternate Phone #:** |  |
| **Parent or Authorized Representative:** | | |  | | |

*\*If any of your information has changed, call the enrollment broker at 800-964-2777:*

***OR*** *Driscoll Health Plan at 1-877-324-7543*.

**Your Hearing Representative’s or Parent’s Information**

You can represent yourself. If you would like someone to represent you such as a parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

**Relationship to the Member:** (Please check one)

( ) Legally Authorized Representative ( ) Family Member ( ) Friend ( ) Provider ( ) Attorney ( ) Provider of Record

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | **Phone:** |  |
| **Address:** |  | **City:** |  |
| **State:** |  | **Zip Code:** |  |

**Reason for the State Fair Hearing**

This section is optional. You can fill it out to tell us about your services under appeal and why you think they are needed.

|  |  |
| --- | --- |
| **Services Under Appeal:** | |
| **Why you need them:** |  |

**Sign this Form:**

By signing this form, you or your authorized representative are requesting a State Fair Hearing and giving the Texas Health and Human Services Commission (HHSC) authorization to obtain your medical records and to contact a representative, if you listed one.

|  |  |  |
| --- | --- | --- |
|  | | |
| **Member/Authorized Representative** | | |
|  |  |  |
| **Printed Name** |  | **Date:** |
|  | | |