Fair Hearing Request Form

A fair hearing is a face-to-face hearing by an impartial State Hearing Officer at a time and place reasonable convenient for the complainant and attended by the complainant or her authorized representatives who may call witnesses or examine witnesses called by other.

Patient Full Name: ____

Date of Birth: ____ / ____ / ____ Medicaid Number: ______________________________

Current Mailing Address: ____
(City, State, Zip)

Telephone Number: ____________________ Alternate Telephone Number: ____________________

Item or service you wish to request a Fair Hearing for: ◯ Claims / payment denial ◯ Benefit dispute

◯ Choice of different physician ◯ Other: ______________________________
(Choose one)

I do not agree with the appeal decision because: ______________________________

____

List any restrictions for attending the Fair Hearing:
(Put an X in days or times you cannot attend)

	M	T	W	Th	F
AM	______	______	______	______	______
PM	______	______	______	______	______

Provide Reason: ____

Signature: ______________________________ ____ / ____ / ____
mm dd yy

Mail this Fair Hearing form and any supporting documentation to:

Alabama Medicaid Agency
PO Box 5624
Montgomery, AL 36103-5624
Attn: Office of General Counsel
Hearings Coordinator

OR Hand Deliver to:

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36104
Attn: Office of General Counsel
Hearings Coordinator