WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES (MEDICAID)
REQUEST FOR HEARING

NAME: _____

ADDRESS: _____

RECIPIENT NAME AND ID #: _____

TELEPHONE NUMBER WHERE YOU CAN BE REACHED: _____

I am requesting a fair hearing for the following reason(s).

_____

_____

Please list service that was denied or terminated. Be as specific as possible. Use the other side of form, if necessary.

You may be contacted by a representative of the Department of Health and Human Resources regarding this request.

You may be requested to participate in a pre-hearing conference (most likely my telephone).

Which type of hearing would you prefer (please check one):

- ☐ All persons participate by telephone conference
- ☐ In person at local office (medical consultant by telephone)
- ☐ Hearing at Bureau for Medical Services office in Charleston (with reimbursement for travel mileage, if requested)

Signature: _____ Date: _____

If hearing is by telephone and you have any documents to present, please mail your documents before the hearing to the hearing examiner whose name is on the hearing notice that you will receive.

If an attorney or other individual will represent you, please list his/her name, address, and telephone number:

_____

_____

_____

Return this request to: Board of Review
Building 6, Capitol Complex
Charleston, West Virginia 25305

A staff member will try to contact you by telephone within approximately five days of receipt of this form.

After the telephone contact, you will be notified in writing the date and time of the hearing

If we are unsuccessful in contacting you by telephone, you will receive written notice of the hearing date and time within 30 days.

WV ADW Program