DEPARTMENT OF HEALTH & HOSPITALS

Request for State Fair Hearing Form

Member Name: _____

Address: _____

City, State, Zip: _____

I want to appeal the decision UnitedHealthcare Community Plan made on my case because:

Date: _____ Signature: _____

Recipient/Representative: _____

Your address if different from the address shown above: _____

_____

Telephone Number: _____

Social Security Number: _____

Email Address: _____

Name, Address and Phone number of your Authorized Representative at the Hearing, if any:

_____

MAIL THIS COMPLETED FORM TO:
(Instead of mailing it, you may fax the form to (225) 219-9823, or you may submit online at http://www.adminlaw.state.la.us/HH.htm.)

Division of Administrative Law – Health And Hospitals Section
P.O. Box 4189
Baton Rouge, LA 70821-4189

The postmark showing the date you mailed your appeal will be the date of your appeal request.

After you ask for a State Fair Hearing, the Division of Administrative Law will send you a Notice by mail of the date, time and location of your State Fair Hearing. If you are unable to mail or fax the attached form, you may phone (225) 342-5800 to give the information for your appeal.