delaware first health

REQUEST TO DELAWARE FIRST HEALTH FOR AN APPEAL

_____ _____ _____

Name Member ID number OR Social Security number

1) I disagree with Delaware First Health decision to reduce, terminate, or deny my request for:

_____

_____

_____

2) I would like to have my Appeal by:

___Phone at the number I have provided here: _____

___In person at the Delaware First Health Office

3) Please check the box that applies:

___I will represent myself at the appeal.

___I would like the following individual to represent me:

_____and_____

Name Relationship to you

4) Please check the box that applies:

___ I would like my benefits to continue during the Appeal process. (In order for benefits to continue, you must file this request within 10 days of this notice being mailed or by the effective date listed on the notice, whichever is later.)

___ I do not want my benefits to continue during the appeal process.

I understand that if I choose to have my benefits continue during the Appeal process and I lose my appeal, **I may be responsible for paying Delaware First Health back for the benefits** I received while the Appeal was pending.

_____ _____

Signature Date

Fax number: <1-833-938-0831>

Delaware First Health
Appeal Coordinator
P.O. Box 10353
Van Nuys, CA 90410-0353

REQUEST FOR STATE FAIR HEARING ON DELAWARE FIRST HEALTH DECISION
(Only after the Delaware First Health appeal process is completed.)

_____ _____ OR _____
Name Medicaid ID number Social Security number

I disagree with the MCO's decision to reduce, terminate, or deny my request for:

_____
_____
_____
_____

Choose one of the following options:

- ☐ I want to continue to receive the benefits that I now receive until my fair hearing is decided. I understand that I may only select this option if my request is filed within 10 days of the notice of resolution letter

- ☐ I do not want to continue receiving the benefits I now receive until my fair hearing is decided.

I understand that if I choose to have my benefits continue during the fair hearing process and I lose the fair hearing, I may be responsible for paying Delaware First Health or the state back for the benefits I received while the fair hearing was pending.

I understand that I may represent myself at the fair hearing or that I may be represented by legal counsel or by another person.

This form may be faxed or mailed to the State Fair Hearing Office.

Fax: <1-302-255-9614>

Mail: <Division of Medicaid & Medical Assistance
DMMA Fair Hearing Officer
1901 North DuPont Highway
P.O. Box 906, Lewis Building
New Castle, DE 19720>

_____ _____
Signature Date

Statement of Non-Discrimination

Delaware First Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delaware First Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delaware First Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- **Delaware First Health: 1-877-236-1341 (TTY: 711)**

If you believe that Delaware First Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Delaware First Health
Appeals & Grievances
PO Box 10353
Van Nuys, CA 90410-0353
Toll Free Number: **1-877-236-1341**
Fax: **1-833-938-0831**

You can file a grievance in person or by mail or fax. If you need help filing a grievance, Delaware First Health is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**, **1-800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Delaware First Health: 1-877-236-1341 (TTY: 711)

English: If you need this in another language, oral interpretation, auxiliary aids and services, or an alternative format, call us. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).
Español (Spanish): Si necesita esto en otro idioma o en un formato alternativo, o si necesita interpretación oral o servicios y dispositivos auxiliares, llámenos. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).
中文 (Chinese): 如您需要以其他語言、口譯、輔助工具和服務或其他文件格式檢閱此資訊，請致電我們。**Delaware First Health**：**1-877-236-1341** (TTY: **711**)。
Kreyòl Ayisyen (Haitian Creole): Si w bezwen sa nan yon lòt lang, entèpretasyon oral, èd ak sèvis oksilyè, oswa yon lòt fòma rele nou. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).
ગુજરાતી (Gujarati): જો તમને આની બીજી ભાષા, મૌખિક ઇન્ટરપિર્ટેશન, સહાયક સહાયતા અને સેવાઓમાં અથવા વૈકલ્પિક ફોર્મેટમાં જરૂર હોય, તો અમને કૉલ કરો. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).
Français (French): Veuillez nous contacter si vous avez besoin de ces informations dans une autre langue ou un autre format, d'une interprétation orale ou d'aide ou de services auxiliaires. **Delaware First Health** : **1-877-236-1341** (TTY : **711**).

한국어 (Korean): 다른 언어, 구두 해석, 보조 도구 및 서비스 또는 대체 형식으로 된 본 자료가 필요하신 경우 당사로 연락하십시오. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Italiano (Italian): Se ha bisogno del presente in un'altra lingua, di un'interpretazione orale, di servizi ausiliari o altri, oppure di un formato alternativo, ci chiami. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Tiếng Việt (Vietnamese): Nếu quý vị cần tài liệu này bằng một ngôn ngữ khác, phiên dịch lời nói, hỗ trợ và dịch vụ phụ trợ, hoặc một định dạng thay thế, hãy gọi cho chúng tôi. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Deutsch (German): Wenn Sie diese Informationen in einer anderen Sprache, eine mündliche Verdolmetschung, Hilfsmittel und zusätzliche Unterstützung oder ein alternatives Format benötigen, rufen Sie uns an. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Tagalog (Tagalog): Kung kailangan ninyo ito sa ibang wika, sa pasalitang interpretasyon, sa mga pansuportang tulong at serbisyo, o sa isang alternatibong format, tawagan kami. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

हिन्दी (Hindi): यदि आपको यह किसी अन्य भाषा, मौखिक व्याख्या, सहायक उपकरण और सेवाओं के साथ चाहिए या आपको किसी अन्य फ़ॉर्मैट में चाहिए, तो हमें कॉल करें. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

اردو (Urdu): اگر آپ کو یہ کسی دوسری زبان میں، زبانی تشریح، معاون امداد و خدمات، یا کوئی متبادل صورت میں چاہیے تو ہم سے رابطہ کریں۔ **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

العربية (Arabic): إذا كنت تريد هذا المستند بلغة أخرى أو إذا كنت تريد ترجمة شفهية أو أدوات مساعدة وخدمات إضافية أو تنسيقًا بديلاً، فيرجى الاتصال بنا. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

తెలుగు (Telugu): మీకు ఇది ఇంకొక భాషలో, మౌఖిక వివరణగా, సహాయక సహాయాలు మరియు సేవలుగా లేదా ఇది ఏ ఇతర రకంగానైనా కావాల్సినవస్తే మాకు కాల్ చెయ్యండి. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).

Nederlands (Dutch): Als u dit in een andere taal nodig hebt, of behoefte heeft aan mondelinge vertolking, ondersteunende hulpmiddelen of diensten, of een ander formaat wenst, bel ons dan. **Delaware First Health**: **1-877-236-1341** (TTY: **711**).