



# AHCCCS Health Insurance Notice of Action



Customer:	AHCCCS ID:	Customer #:
	Date:	
	Eligibility Specialist:	
	Phone:	
	Fax:	

### PLEASE READ THIS ENTIRE NOTICE

**This decision affects medical benefits for:** \_\_\_\_\_

- AHCCCS Medical Services approved:** Beginning \_\_\_\_\_ you are eligible for AHCCCS Health Insurance benefits.
  - You will be enrolled with an AHCCCS health plan. If you have been eligible for AHCCCS Health Insurance within the last 90 days, enrollment will remain with the previous health plan. Otherwise, enrollment will be with the AHCCCS health plan you chose. If you did not choose a health plan, one will be assigned to you.
  - You must immediately report all changes in your household to your Eligibility Specialist. Your reporting responsibilities are explained on the back of this notice.

- Medicare Cost Sharing approved:** Beginning \_\_\_\_\_ you are eligible for Medicare Cost Sharing benefits under the Qualified Medicare Beneficiary (QMB) program.
  - QMB benefits pay for your Medicare costs. This includes the Medicare Part B premium, co-insurance, deductibles, and the Medicare Part A premium for persons who are required to pay for Medicare Part A.
  - You must immediately report all changes in your household to your Eligibility Specialist. Your reporting responsibilities are explained on the back of this notice.

- Ineligible for some months only:** Although you are being approved for on-going AHCCCS health insurance, you are ineligible for the following months: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, because: \_\_\_\_\_.

This action is based on the following regulations and Policy Manual Section(s): \_\_\_\_\_.

### Hearing Rights

You have a right to request a fair hearing regarding any of the decisions listed on this notice. To be guaranteed a hearing, you must file your request for a hearing by \_\_\_\_\_. Your fair hearings rights are more thoroughly explained on the back of this notice.

- If you have any questions, please call:**
- 1-800-528-0142 toll free from area codes 520, 760 or 928 or
  - 602-417-5010 from area codes 480, 602 or 623.

**IN ENGLISH**

**REPORTING RESPONSIBILITIES:**

You must immediately report all changes in circumstances including changes in income, marital status, address, phone number, persons moving in or out of your home, a move out of state, the death of a person in your household, or a change in medical insurance coverage.

**HEARING RIGHTS:**

You may request a hearing to present evidence concerning the decision made by AHCCCS regarding your medical benefits. If you wish to request a hearing, your request must be in writing and received by AHCCCS no later than the date listed on the front of this notice. If you are appealing a discontinuance of your AHCCCS medical benefits and your request is received by AHCCCS before the effective date of the proposed action which is included on the denial or discontinuance notice, your benefits will continue until a hearing decision is made. **If the hearing decision is not in your favor, you may be required to repay the State for the medical benefits you received while the hearing decision was pending. Even if you already have a hearing pending, you may file another hearing request concerning the decision on this notice.**

**You can mail or fax your request for hearing. Mail your request to the AHCCCS Administration, Office of Legal Assistance, 701 E. Jefferson, MD 6200, Phoenix, Arizona 85034, or by FAX to: 602-253-9115.** You may use the bottom of this notice to request your hearing by completing the information and mailing or faxing as instructed above. If you have questions, need help in completing this form, or want a Pre-hearing Discussion to review the proposed denial or discontinuance with an AHCCCS Staff member, call the eligibility office phone number listed on the denial or discontinuance notice.

Your **hearing** will be heard by an Administrative Law Judge and a decision will be issued by the AHCCCS Director. You may review your case file **at the local office prior to** the hearing. You may represent yourself at the hearing, be represented by an attorney or any other person you choose. For free legal advice, contact Community Legal Services at: Phoenix 1-800-852-9075; Tucson 1-800-234-7252; Flagstaff 1-800-789-5781 or the legal services in your area.

The references listed on the denial or discontinuance notice are available through public or law libraries or at the AHCCCS eligibility office. The abbreviation USC means United States Code, PL means Public Law, CFR means Code of Federal Regulations, ARS means Arizona Revised Statutes, AAC means Arizona Administrative Code, and MS refers to the specific Manual Sections of the Eligibility Policy and Procedural Manuals.

**EN ESPAÑOL**

**RESPONSABILIDADES DE REPORTAR:**

Usted debe reportar inmediatamente todos los cambios en circunstancias incluyendo cambios en renta, personas que se mudan en o fuera de su hogar, al mudarse del estado, la muerte de una persona en su hogar, o algún cambio en cobertura de seguro médico.

**DERECHOS DE AUDIENCIA:**

Usted puede solicitar una audiencia para presentar la evidencia referente a la decisión tomada por AHCCCS con respecto a sus beneficios médicos. Si usted desea solicitar una audiencia, su petición debe ser por escrito y recibida por AHCCCS no más tarde de la fecha alistada en el frente de este aviso. Si usted está apelando la discontinuación de sus beneficios médicos de AHCCCS, y su petición es recibida por AHCCCS antes de la fecha efectiva de la acción propuesta, la cual está en el aviso de negación o discontinuación, sus beneficios continuaran hasta que una decisión sea tomada por medio de una audiencia. Si la decisión no es en su favor, puede ser que se le requiera a usted compensar al estado por beneficios médicos que usted haya recibido mientras esperaba por la decisión. Incluso si usted tiene ya una audiencia pendiente, usted podría solicitar otra audiencia referente a la decisión en este aviso.

**Envíe su petición a la administración de AHCCCS, Oficina de Asistencia Legal, 701 E. Jefferson, MD 6200, Phoenix, Arizona 85034, FAX: 602-253-9115.**

Usted puede usar la parte de abajo de este aviso para solicitar una audiencia, completando la información y enviándola según las instrucciones mencionadas arriba. Si usted tiene preguntas, necesita ayuda en llenar este formulario, o quiere una pre-audiencia para revisar la propuesta de negación o discontinuación con un miembro del personal de AHCCCS, llame al número de teléfono de la oficina de elegibilidad alistado en este aviso de negación o discontinuación.

Su caso será escuchado por un Juez de Leyes Administrativas y la decisión será emitida por el Director de AHCCCS. Usted podrá revisar su expediente de caso en la oficina local antes de la audiencia. En la audiencia, puede representarse usted mismo, o por un abogado o cualquier persona que usted escoja. Para asesoramiento legal gratuito, llame a los Servicios Legales de la Comunidad a los siguientes teléfonos: Phoenix 1-800-852-9075; Tucson 1-800-234-7252; y en Flagstaff 1-800-789-5781.

Las referencias enumeradas en el aviso negación o de discontinuación están disponibles a través de las bibliotecas públicas o legales o en la oficina de elegibilidad de AHCCCS. La abreviatura USC significa Código de Estados Unidos, PL significa Derecho Público, CFR significa Código de Reglamentos Federales, ARS significa Estatutos Revisados de Arizona, AAC significa Código Administrativo de Arizona, y MS se refiere a secciones específicas del Manual de Reglas y Procedimientos de Elegibilidad.

✂ ----- CUT HERE - CORTE AQUÍ -----

I request a hearing for the denial or discontinuance of my medical benefits. Solicito una audiencia para la negación o la discontinuación de mis beneficios médicos.

Please print name of Customer (Last, First, MI) - Por favor, imprima el nombre del Cliente	Customer I.D.	Customer's Social Security No. No. de Seguro Social del Cliente.
Customer's Address (Street, City, State, Zip) - Direccion del Cliente (Calle, Ciudad, Estado, Codigo Postal)		Phone Number - Número Telefonico
Please sign your name and check the appropriate box - Por favor, firme su nombre y marque el espacio apropiado		Customer - Cliente Representative - Representante
EXPLAIN WHY YOU WANT A HEARING - Explique Por Qué Desea Usted Una Audiencia		