Texas Children's Health Plan
P.O. Box 300709, WLS 8390
Houston, TX 77230-1011
Fax: 832-825-8796

Member Notice of Internal Appeal Decision

State Fair Hearing and External Medical Review Request Form

To ask for a State Fair Hearing and External Medical Review, you can call us 1-866-959-2555 for STAR or 1-800-659-5764 for STAR Kids, email us at TCHPUM@texaschildrens.org or you can fill out this form and mail or fax it to us.

Texas Children's Health Plan
Attn: UM Department
P.O. Box 301011, WLS 8390
Houston, TX 77230-1011
Fax: 832-825-8796

You must request a State Fair Hearing by **<date 120 Days from the date this notice is mailed>**.

If you kept receiving services during your Health Plan Appeal, you may be able to keep getting your services during your State Fair Hearing. Make your request by **<date must be the later of the following: date 10 Days from the date this notice is mailed, or the date services will change>** only if you kept services during your Health Plan Appeal.

Mark the State Fair Hearing option you want:

Only select one.

____State Fair Hearing
____State Fair Hearing and External Medical Review
____Emergency State Fair Hearing*
____Emergency State Fair Hearing and External Medical Review*

*Emergency State Fair Hearings and Emergency External Medical Reviews should only be requested if you believe your health will be seriously harmed by waiting for your State Fair Hearing or Emergency External Medical Review decisions.

<Denial Reference Number: Number>

Do you want your services to continue?_____Yes_____No

Your services can only be continued if they were also continued during your Health Plan Appeal. If you want your services to continue, you must request a State Fair Hearing and ask to keep your services by **<date must be the later of the following: date 10 Days from the date this notice**

is mailed or the date services will change>. You can make this request by phone. Call us at 1-866-959-2555 for STAR or 1-800-659-5764 for STAR Kids if you think this form will not reach us by mail before the deadline

Your Personal Information*

Member last name:	Member first name:
Parent or guardian last name:	Parent or guardian first name:
Member Medicaid ID and subscriber number:	Preferred phone number:

*If any of your contact information has changed, call the Enrollment Broker at 800-964-2777 and Texas Children's Health Plan at 1-866-959-2555 for STAR or 1-800-659-5764 for STAR Kids.

Your Hearing Representative's or Parent's Information

You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Reason for the State Fair Hearing

This section is optional. You can fill it out to tell us about your services under appeal and why you think they're needed.

Services under appeal:

Why you need them:

Sign this form

By signing this form, you or your representative are requesting a State Fair Hearing and giving the Texas Health and Human Services Commission authorization to get your medical records and to contact a representative if you listed one.

Member/Authorized representative signature

Printed name

Date