SoonerSelect

Request for State Fair Hearing

[Form LD-1S]

If you previously filed an appeal or grievance with your CE (contracted entity) or DBM (dental benefit manager), you may request a state fair hearing through OHCA after receiving notice from your CE or DBM upholding the original adverse benefit determination.

Please note, you have one-hundred twenty (120) days from the date of the adverse benefit determination notice to request a state fair hearing. **Failure to complete and return this form within 120 days of your adverse benefit determination notice can result in a dismissal or denial of your appeal**.

Please provide all requested information, including a complete explanation of the problem/issue. Include the name(s) of any CE, DBM, or OHCA personnel with whom you have dealt and the dates on which specific events occurred. Use additional paper if necessary. Attach copies of any supporting documentation you would like to be considered.

PLEASE ATTACH A COPY OF THE FINAL NOTICE OF ADVERSE BENEFIT DETERMINATION.

MEMBER INFORMATION

Member Name: _____ Member ID: _____

Member Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Date of Adverse Benefit Determination or exhaustion of the CE or DBM appeal process: _____

Member CE or DBM: _____

Member's Guardian (if applicable): _____ Guardian Phone: _____

Authorized Representative (if any):

I, _____ authorize _____ to serve as my representative in connection with this state fair hearing appeal. I authorize my representative to present evidence, to obtain information about my appeal, and to receive notices in connection with my appeal. I understand that my personal health information (PHI) may be disclosed to my Representative. I understand that my PHI may include information about drug or alcohol disorders or treatment, mental health disorders or treatment, and communicable or non-communicable diseases. By signing this form, I am authorizing disclosure of this information. My representative will be available to represent me on the date and time of the appeal hearing as set by the Oklahoma Health Care Authority. I do not have a legally appointed Guardian, or my legally appointed Guardian hereby consents to this authorization.

Member Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Authorized Representative Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Please tell us about your request in the space below. Be as specific as possible and whenever possible, give the date(s) on which the event occurred. Please include what you would like OHCA to do about this issue. (*If you need more space, use another sheet of paper).*

Member Signature _____ **Date** _____

PLEASE SEND THIS FORM TO:

Oklahoma Health Care Authority
Grievance Docket Clerk
P.O. Drawer 18497
Oklahoma City OK 73154-0497

Fax: 405-530-3444
Phone: 405-522-7217
Email: docketclerk@okhca.org