HIGHMARK. HEALTH OPTIONS

State Fair Hearing Request Form

Member Information	
Today's Date	**Member ID Number**
First Name	**Last Name**

I disagree with Highmark Health Options' decision to reduce, terminate, or deny services for:

_____

_____

I disagree because: (If more space is needed, use additional paper.)

_____

_____

_____

_____

Choose one of the following options:

☐ I want to continue to receive the medical and pharmacy benefits that I now receive until the outcome of my State Fair Hearing is decided. I understand that I may only select this option if my request is filed within **10 days** of this notice being mailed or by the effective date listed on the notice, whichever is later.

☐ I do not want to continue receiving the medical and pharmacy benefits I now receive until the outcome of my State Fair Hearing is decided.

I understand that if I choose to have my benefits continue during the State Fair Hearing process and I lose the State Fair Hearing, I may be responsible for paying Highmark Health Options or the state back for the benefits I received while the State Fair Hearing was pending.

I understand that I may represent myself at the State Fair Hearing or that I may be represented by legal counsel or by another person.

_____ _____

Signature **Date**

Fax or mail the completed form to the State Fair Hearing Office.

Fax: 1-302-255-9614

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

Last updated: Apr. 13, 2021