DentaQuest | Children's Medicaid | TEXAS Health and Human Services

State Fair Hearing and External Medical Review Request Form

To ask for a state fair hearing and external medical review, you can call us at 1-800-516-0165 (TTY: 711), or mail or fax this form to us.

Mail: DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906

Fax: 800-936-0913

You must request a state fair hearing by <date of letter+120 days>.

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 of letter+10 days> 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 emergency 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 fair hearing or external medical review decisions.

Reference Number: <CGA Case 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 of letter+10 days>.

You can make this request by phone. Call us at 1-800-516-0165 (TTY: 711) if you believe 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 DentaQuest at 1-800-516-0165 (TTY: 711).

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