**< YOUR AGENCY NAME HERE>**

**REQUEST FOR INTERNAL REVIEW/LOCAL APPEAL**

**Instructions to the requestor:**

1. Please complete the form below. Assistance is available by calling your local Appeals Officer, Customer Services, or your local Office of Recipient Rights at <local number here>.

2. You must file for your Local Appeal within 30 days of this Adverse Benefit Determination.

4. The review and decision will occur within 45 days.

5. You will receive written notification of the decision of the local appeals committee and subsequent avenues if you are not satisfied with the results.

6. After you have completed this form, please mail it to:

<INSERT HERE: Agency address/contact information here>

ATTN: INSERT HERE: <Agency’s Local Appeals Officer/Customer Service Staff Name>

**To be completed by the requestor:**

**I WANT TO REQUEST A REVIEW OF MY APPEAL. Here are my reasons for this request:**

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Your Signature Date Your Name (Print)

Your Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may represent yourself or have anyone you would like represent you. If you want someone else to represent you at the internal appeal, called an **Authorized Hearing Representative (AHR),** please complete their contact information below. You can still be involved and present at the appeal if you have an AHR.

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| --- | --- | --- | --- | --- |
| Name of Representative | | | Representative Telephone Number  **(**       **)** | |
| Address (No. & Street, Apt. No.) | | | Representative Signature | Date Signed |
| City | State | ZIP Code | Relationship to Client: |  |