Children's Mental Health Bureau (CMHB)
DPHHS

Montana Medicaid Youth
Claimant Fair Hearing Request Form

Please type or print clearly. Processing may be delayed if information submitted is illegible or incomplete.

Parent/legal custodian or their authorized representative, for youth who receive Medicaid reimbursed mental health services have the right to request a fair hearing if aggrieved by a denial or adverse determination/action by the department. Adverse action is defined in ARM 37.5.304.

You may use this form to request a fair hearing from the Office of Fair Hearing (OFH). It would be helpful to send a copy of the request to the Children's Mental Health Bureau (CMHB). Please inform or coordinate your request with the provider.

DATE OF REQUEST: _____ **REQUEST ID #:** (Located on the adverse determination letter)

A written request for a fair hearing must be received by the OFH within 90 days from the mailing date of the initial denial. The OFH address is at the bottom of this form. The OFH will give CMHB 20 days to complete an administrative review of the adverse determination, prior to scheduling a fair hearing. If the denial is upheld by CMHB, a fair hearing may be conducted if the parent or legal custodian wish to proceed.

Check the type of denial this request relates to.

☐ Technical Denial (Not based on lack of medical necessity; See ARM 37.87.903)

☐ Clinical Denial **(A reconsideration review should be requested first because the clinical basis for the determination of lack of medical necessity will not be reviewed during the administrative review and fair hearing process but the technical and procedural issues pertinent to the adverse determination will be considered.)**

Requestor Information			
Requestor: ☐ Parent/Legal Custodian ☐ Authorized Representative ☐ Both			
PARENT OR LEGAL CUSTODIAN NAME:			
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE NUMBER:	**OTHER KNOWLEDGEABLE PARTIES WHO CAN BE CONTACTED:**		
AUTHORIZED REPRESENTATIVE NAME:			
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE NUMBER:	**OTHER KNOWLEDGEABLE PARTIES WHO CAN BE CONTACTED:**		

Send this Fair Hearing Request Form to:
Office of Fair Hearings
P.O. Box 202953
Helena, MT 59620-2953

Youth Information				
NAME:			**MEDICAID NUMBER:**	
ADDRESS		**CITY**	**STATE**	**ZIP**
SSN:	**DOB:**	**IS THE YOUTH IN STATE CUSTODY?** ☐ Yes ☐ No	**GENDER:** ☐ Male ☐ Female	
CUSTODY: ☐ Parent ☐ CFSD ☐ Juvenile Probation ☐ Tribal ☐ Other				

Answering the following questions on this form will assist CMHB in conducting their administrative review. It would be helpful to attach any documents and information the requestor wishes the department to consider in the administrative review. If a parent/legal custodian uses an authorized representative, written authorization must be included with their request.

Please detail your objection to the adverse determination, including the specific reasons why CMHB should overturn the determination.

Please add detail about any substantiating documents or circumstances you wish CMHB to consider along with the documents you attached.

Please provide any additional information you consider relevant to the administrative review and fair hearing.

CMHB and OFH only consider the clinical information that was available to the UMC clinical reviewers and appellate physicians during a clinical denial administrative review and fair hearing. If the youth's clinical condition has changed, a new initial authorization request should be submitted by the provider.

Send this Fair Hearing Request Form to:
Office of Fair Hearings
P.O. Box 59620-2953
Helena, MT 59620-2953