State Fair Hearing and External Medical Review Request Form

To get a state fair hearing and external medical review, you can call us at **1-888-657-6061** (TTY **711), email us at GPDTXMedicaidAG@bcbsnm.com.** You can also mail or fax the form to us.

Blue Cross and Blue Shield of Texas
C/O Complaints and Appeals Department
P.O. Box 660717
Dallas, TX 75266
Fax: 1-855-235-1055

If you want your services to continue, you must make your request by **120 days from the date this notice was mailed.**

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 **10 Days from the date this notice was mailed, or by the date services will change,** only if you kept services during your health plan appeal.

Mark the Appeal You Want
Select one option below.

___ 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 review should only be requested if you believe your health will be seriously harmed by waiting for your fair hearing or external medical review decisions.

<Denial Reference Number: Number>

Do you want your services to continue? _____Yes _____No

Your services can only be continued if they were also continued during yourhealth plan appeal. If you want your services to continue, you must requesta state fair hearing and ask to keep your services by **<date must be the later of the following: date 10 Days from the date this notice is mailed, or the date services will change>**.

You can make this request by phone. Call us at **1-888-657-6061** (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 or Social Security Number:	Phone Number:

*If any of your contact information has changed, call the enrollment broker at **1-800-964-2777** and BCBSTX at **1-888-657-6061** (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:

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.

Date _____

Member/Authorized representative signature Print Name

_____ _____