REQUEST FOR A FAIR HEARING

To: Office of Health Services
Attention: Dina Smoot
201 W. Preston Street
Baltimore, MD 21201

Name:_____

Address:_____

_____

Telephone Number: _____

Medical Assistance Number (found on your Medicaid Card)_____

I disagree with my Managed Care Company's decision because:_____

_____

_____

_____

_____

_____

_____

_____

Please schedule my fair hearing with 20 days of the date you receive this request.

Thank you,

_____
Signature