Division of Medicaid Services F-00237 (02/2021)

## STATE OF WISCONSIN Wis. Stats. § 46.287(2)(c)

## APPEAL REQUEST – MY CHOICE WISCONSIN BY MOLINA HEALTHCARE Completing this form is voluntary. Personally identifiable information collected on this form is

used to identify your case and process your request only. Name – Member Today's Date Mailing Address City State Zip Code WI Check this box if you would like to appeal My Choice Wisconsin's decision by requesting a meeting with the My Choice Wisconsin Grievance and Appeal Committee. Continuing your services during an appeal of a reduction, suspension, or termination of a service If you are getting benefits and you ask for an appeal before your benefits change, you can keep getting the same benefits until a decision on your appeal has been made. If you want to keep your benefits during your appeal, your request must be postmarked or faxed on or before the effective date of the intended action. If the Grievance and Appeal Committee decides that My Choice Wisconsin's decision was correct, you may need to repay the extra benefits that you got between the time you asked for your appeal and the time that the Grievance and Appeal Committee makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost. ☐ Check this box if you would like to request the same services to continue during your appeal. Copy of your case file You have a right to a free copy of the information in your case file related to your appeal. Information means documents, records and other related material including any new or additional information My Choice Wisconsin gathers during your appeal. Check this box if you would like to receive the information in your case file from My Choice Wisconsin related to your appeal. **SIGNATURE** – Member Date Signed Mail or fax this form to: My Choice Wisconsin Attn: Member Rights 10201 W Innovation Dr. Suite 100 Wauwatosa WI 53226-4822 Fax: 608-245-3821

To start your appeal as soon as possible, you can call My Choice Wisconsin at 1-800-963-0035 or 608-245-3448 before mailing this form. TTY users should call 711.

Your appeal must be postmarked or faxed no later than **60 calendar days** from the date on the Notice of Adverse Benefit Determination.

## My Choice Wisconsin:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call My Choice Wisconsin at 1-800-963-0035, Monday through Friday, 8 a.m. to 4:30 p.m. TTY users should call 711.