Parkland
Community Health Plan
PO Box 560347
Dallas, TX 75356

PARKLAND HEALTHFIRST STATE FAIR HEARING AND EXTERNAL MEDICAL REVIEW REQUEST FORM

To ask for a State Fair Hearing and External Medical Review, you can call us at **1-888-672-2277** (toll-free), email us at PCHPComplaintsandAppeals@PHHS.org or mail or fax this form to us.

Mail:

Parkland Community Health Plan
Attention: Member Advocate
PO Box 560347
Dallas, TX 75356

Fax:

1-844-310-1823

You must request a state fair hearing by <date 120 Days from the date this notice is 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 <date must be the later of the following: date **10 days** from the date this notice is mailed, or the date service will change> only if you kept services during your health plan appeal.

Mark the state fair hearing option you want: Only select one.

___ 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 reviews 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: <CaseID>

Do you want your services to continue? ___ Yes ___No

Your services can only be continued if they were also continued during your health plan appeal. If you want your services to continue, you must request a 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>.

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You can make this request by phone. Call us at **1-888-672-2277** (toll-free) 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 and subscriber number:	Preferred phone number:

*If any of your contact information has changed, call the enrollment broker at 800-964-2777 or Parkland Community Health Plan at 1-888-672-2277 (toll-free).

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.

Service under appeal:
Why you need them:

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Sign this form:

By signing this form, you or your authorized 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.

Member/Authorized representative signature
Printed name
Date