



North Carolina Department of Health and Human Services
Hearings and Appeals Section

2418 Mail Service Center • Raleigh, North Carolina 27699-2418
Tel: 919-855-3260 • Fax: 984-687-9593 • ZixMail: Medicaid.DSS.State.Appeals@dhhs.nc.gov

REQUEST FOR STATE APPEAL

(To be completed by County DSS & submitted by ZixMail within 5 days of Appeal Request Date to Medicaid.DSS.State.Appeals@dhhs.nc.gov)

County: DSS Address: (If multiple county offices, be sure to indicate the correct office location)

DSS Worker: DSS Supervisor:
Phone # Ext. Phone # Ext.
E-mail E-mail

Date of Appeal Request: Check box if this is a duplicate to send updated or additional case information/evidence

Appellant: SSN:
Address: DOB:
City, State, Zip Phone #
Sex: Male / Female Alternate Phone #

Date of Application: PDC (IMC) # or PI Claim #

Indicate type of Hearing requested: (Must check one block - In accordance with 10A NCAC 21A .0304, Appellant must select the mode of the hearing at the time this State Appeal is requested.)

- In-Person Hearing at the county DSS office
Remote Phone Hearing Check when attempts to reach client to confirm mode are unsuccessful
Remote Video Hearing using Microsoft TEAMS - must include e-mail address for a video hearing

Representative: Yes or No (Check here if multiple representatives & attach a sheet to include contact information if more than one representative needs to be listed.)

Representative Name:

Title: (Attorney, Hospital worker, Relative, Friend, etc.)

Address:

Phone #: E-mail address:

Reasonable accommodations needed free of charge in order to participate in State hearing process:

- Interpreter, What language: _____
- Other accommodation, Explain: _____

Attach the following to this Request for State Appeal: *(Check items attached.)*

- Copy of DSS notification letter to grant, deny, terminate, or modify assistance that prompted appeal *(DMA 5024, 5059, 5102, 5119, etc., DSS 8108, 8109, 8110, 8551, 8553, 8556, 8558, 8586, 8587, 8588, 8632, 8639, 8642, etc.).*
- Copy of relevant documents related to appeal *(application/recertification/trial budgets/MRA/5097s/5013/ etc. & citation of the specific regulations that was the basis for the County's action).*
- Copy of local appeal hearing summary & decision, if applicable.
- Copy of D4037 Medicaid Disability Determination Transmittal from DDS, if applicable.
- Copy of DMA-5135 and all related medical records, if applicable. *(Appeal issue involves the medical decision made on an Emergency Medical Assistance claim.)*
- If PI, copy of completed DSS-1473A Addendum for Program Integrity
- If Expedited Medicaid Appeal, copy of completed DSS-1473B Addendum & Medical Evidence

Program: *(Check one block. If appealing actions in multiple programs, then separate Appeal Request Forms must be prepared for each program.)*

- | | |
|---|--|
| <input type="checkbox"/> MAA | <input type="checkbox"/> Adoption Assistance |
| <input type="checkbox"/> MAA–Emergency Ser.MID # _____ | <input type="checkbox"/> CAP/DA |
| <input type="checkbox"/> MAB | <input type="checkbox"/> CIP |
| <input type="checkbox"/> MAB–Emergency Ser.MID # _____ | <input type="checkbox"/> LIEAP |
| <input type="checkbox"/> MAD | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> MAD–Disagrees <u>DDS</u> disability decision | <input type="checkbox"/> FNS |
| <input type="checkbox"/> MAD- Emergency Ser.MID # _____ | <input type="checkbox"/> FNS – SNAP (Simplified) |
| <input type="checkbox"/> MXP (Medicaid Expansion) | <input type="checkbox"/> FNS - Disaster |
| <input type="checkbox"/> MAF | <input type="checkbox"/> FNS-ADH (IPV Disqualification - PI) |
| <input type="checkbox"/> MAF–Emergency Ser.MID # _____ | <input type="checkbox"/> FNS-IPV Overissuance (PI) |
| <input type="checkbox"/> MIC | <input type="checkbox"/> FNS-IHE Overissuance (PI) |
| <input type="checkbox"/> MIC–Emergency Ser.MID # _____ | <input type="checkbox"/> FNS-AE Overissuance (PI) |
| <input type="checkbox"/> MPW | <input type="checkbox"/> SA |
| <input type="checkbox"/> MPW–Emergency Ser.MID # _____ | <input type="checkbox"/> SAA |
| <input type="checkbox"/> MQB | <input type="checkbox"/> SAD |
| <input type="checkbox"/> Medicaid Transportation | <input type="checkbox"/> Work First |
| <input type="checkbox"/> NCHC | <input type="checkbox"/> Work First Program Integrity |
| <input type="checkbox"/> HCWD | <input type="checkbox"/> Other: _____ |

Appealable Issue for State Hearing: (Check one block. If appealing multiple actions, then separate 1473s must be prepared)

Application denied – DSS Reason:

Denied for failing to timely provide information – DSS Reason (*what was needed*):

Benefits/Services terminated – DSS Reason:

Benefits/Services reduced/modified/changed – DSS Reason:

Charged an overissuance – DSS Reason:

Administrative Disqualification – DSS Reason:

Other (*Explain*):

If applicable, Continuation of Benefits requested: Yes or No

(DSS Worker Completing form)

(Date completed)

(DSS Worker's direct phone #)