The MOM Care Program
Fair Hearing Request Form

A fair hearing is a face-to-face hearing by an impartial State Hearing Office at a time and place reasonable convenient for the complainant and attended by the complainant or her authorized representatives who may call witnesses or examine witnesses called by other.

Patient Full Name: ____

Date of Birth: ___/___/____ Medicaid Number: ________________________________

Current Mailing Address

____

Telephone Number: ____________________ Alternate Telephone Number: ____________________

Items or service you wish to request a Fair Hearing for : ◯ Claims/payment denial
◯ Benefit dispute ◯ Choice of different physician ◯ Other: ___________________________

I do not agree with the appeal decision because:

____

____

List any restrictions for attending the Fair Hearing:
(Put an X in days or times you cannot attend)

	M	T	W	TH	F
AM	_____	_____	_____	_____	______
PM	_____	_____	_____	_____	______

Provider Reason: ____

Signature: _____________________________________ Date: ___/___/_____

Mail this Fair Hearing form and any supporting documentation to:

Alabama Medicaid Agency
PO Box 5624
Montgomery, AL. 36103-5624
Attn: Office of General Counsel Hearing Coordinator

OR Hand Deliver to:

Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL. 36104
Attn: Office of General Counsel Hearing Coordinator