

**DISTRICT OF COLUMBIA
Office of Administrative Hearings**

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**REQUEST FOR HEARING IN DEPARTMENT OF HEALTH CARE FINANCE (DHCF) CASES-
MEDICAID COVERAGE (NOT ELIGIBILITY)**

SECTION 1 – CONTACT INFORMATION

Name (please print): _____	Attorney/Representative (if any): _____
Address: _____ _____	Address: _____ _____
Telephone: _____	Telephone: _____
Email: _____	Email: _____

SECTION 2 – BENEFITS INFORMATION

Petitioner is a: ☐ **RECIPIENT** of benefits (If Petitioner is an Applicant, DHS hearing request form should be used)

Medicaid ID Number: _____ Name of Medicaid Provider: _____

Address of Medicaid Provider: _____

SECTION 3 – AGENCY ACTION or Inaction/REASON FOR HEARING REQUEST

PLEASE ATTACH A COPY OF THE NOTICE YOU RECEIVED FROM THE AGENCY.

- ☐ **Termination of Personal Care Aide (PCA) services** under the Medicaid or EPD Waiver program
- ☐ **Reduction of Personal Care Aide (PCA) services** under the Medicaid or EPD Waiver program
- ☐ **Denial of coverage for durable medical equipment, prosthetics, orthotics, or supplies**
- ☐ Denial of coverage for **dental services** ☐ Denial of coverage for **prescription(s)**
- ☐ Denial of coverage for **surgery** ☐ Denial of coverage for **hospitalization** ☐ Denial of coverage for **transportation**
- Request for coverage or service(s) not acted upon or not acted upon with reasonable promptness
- ☐ **Other** (please specify): _____

Please include a brief description of why you disagree with the action or inaction and what relief you are seeking:

SECTION 4 – LANGUAGE ACCESS

Do you need language interpretation?

☐ YES ☐ NO

If YES, specify language: _____

SECTION 5 – ACCOMMODATIONS FOR DISABILITY

Do you need reasonable accommodation for disability at hearing?

☐ YES ☐ NO

If YES, please specify: _____

SECTION 6 – OTHER REQUIRED INFORMATION

How was this request filed at OAH? ☐ In Person ☐ By Telephone ☐ By Fax/Email ☐ By Postal Mail

Name of person preparing request (if completed by someone other than Petitioner): _____

Signature: _____

Date: _____