

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH CARE FINANCE**

**HEARING REQUEST FOR MEDICAID PROGRAMS  
AND HEALTH CARE ALLIANCE**

**SECTION I - CONTACT INFORMATION:**

Name of Person who wants a Hearing (**please print**): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**SECTION II – BENEFITS INFORMATION:**

I am: \_\_\_\_\_ APPLICANT for benefits \_\_\_\_\_ RECIPIENT  
of benefits and ID Number \_\_\_\_\_

I am requesting a hearing because I disagree with the agency action(s) for the following programs:

\_\_\_\_\_ MEDICAID PROGRAMS                      \_\_\_\_\_ HEALTH CARE ALLIANCE

**SECTION III - AGENCY ACTION TAKEN:**

What kind of action has the agency taken?

- \_\_\_\_\_ Denial of application for benefits
- \_\_\_\_\_ Denial of specific service (**specify**): \_\_\_\_\_
- \_\_\_\_\_ Termination of benefits (specify): \_\_\_\_\_
- \_\_\_\_\_ Reduction of Benefits
- \_\_\_\_\_ Request for service(s) not acted upon with reasonable promptness
- \_\_\_\_\_ Other (**specify**): \_\_\_\_\_

**SECTION IV – ACCOMMODATIONS:**

Do you require special services of any kind at the hearing? (Language translation, sign language interpreter, etc.)

\_\_\_\_\_ YES    \_\_\_\_\_ NO    (**If yes, what type of service is required?**) \_\_\_\_\_

**SECTION V - ATTORNEY (OR) OTHER REPRESENTATIVE:**

Name: \_\_\_\_\_ Bar No: \_\_\_\_\_

Firm name, if any \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_

**SECTION VI - AGENCY INFORMATION:**

Request received:

\_\_\_\_\_ In person

\_\_\_\_\_ Telephone

\_\_\_\_\_ Fax

\_\_\_\_\_ E-mail

\_\_\_\_\_ Agency Assisted or Prepared (If yes, please list preparer) \_\_\_\_\_

**SECTION VII – PERSON PREPARING REQUEST:**

Please print your name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Office of the Health Care Ombudsman and Bill of Rights  
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Washington, DC 20002  
1-877-685-6391  
202-724-7491**