GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

REQUEST FOR HEARING BY MEDICAID PROVIDER

MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
BENEFIT SERVICES DIVISION
P.O. Box 30763
Lansing, MI 48909
FAX: 517-241-0146

(Please complete fully)

Name of Provider:			Title:
Name of Attorney or Hearing Representative:			Title:
Provider's Medicaid Contract No:			
Business Address: (No. & Street)			Suite #:
City:	State:	Zip Code:	
Provider Business Telephone No: ( )			
Provider Fax No: ( )			

This is to request a hearing to appeal a Determination by the Michigan Department of Health and Human Services (DHHS) issued on:

A copy of the Determination is attached:

Yes: ☐ No: ☐

The Provider's reason(s) for appealing the DHHS Determination is as follows:

_____

_____

SEND COMPLETED FORM BY MAIL OR FAX TO:

MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
BENEFIT SERVICES DIVISION
Attn: Medicaid Provider Appeals
P.O. Box 30763
Lansing, MI 48909
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(25 pages maximum for faxing; if over 25 pages, please mail.)