(MI Choice Provider Letterhead)
Adverse Action Notice

Adequate Action Notice – MI Choice Waiting List Removal

Date:

Name:
Address:
City, State, Zip code

Dear _____:

Following a review of your long term care needs, you will be removed from the MI Choice waiting list for the following reason as specified in the MI Choice Policy Chapter of the Michigan Medicaid Provider Manual: _____. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request a **Medicaid Fair Hearing**. To request a Medicaid Fair Hearing, complete a DCH-0092 – Request for an Administrative Hearing form and mail it to:

Request for Administrative Hearing
Michigan Administrative Hearing System
Michigan Licensing and Regulatory Affairs
PO Box 30763
Lansing, Michigan 48909

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice,**
- In writing, and
- Signed by you or a person authorized to sign for you.

Sincerely,
(Provider Representative)