



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**  
**Fair Hearing Request**

HW 0406 - IBHP  
Revised 1/2016

You have the right to request a Fair Hearing with IDHW if you are not satisfied with an Optum decision for outpatient behavioral health services available in the Idaho Behavioral Health Plan (IBHP). Fair Hearing requests **must be in writing and must be filed within 28 days from the date the denial notice from OPTUM is mailed**. You may choose to have someone help you with this such as your legal guardian, if you have one, or your provider. You can use this form or send in your request in a letter. Your request must:

- Explain why you disagree with the decision (include any information you think should have been considered, and was not)
- Include a copy of Optum's denial notice
- State if you want to continue services during the Fair Hearing process. (If currently authorized services are being terminated or reduced and you would like to continue receiving services you must request a hearing within ten (10) days of the postmark of this notice. When you request a continuation of service, you may continue receiving services until the fair hearing is held and a decision is mailed to you, or the current authorized service expires whichever comes first. If the hearing officer decides that Optum's action was correct, Optum may take action to collect the cost of those benefits from you, as allowed by 42 CFR 431.230(b).)

If you need help with this form or with the process you can call Idaho Medicaid at 1-866-681-7062.

**What services did you request?**

I disagree with Optum's decision on my request for the following services:

From Idaho Behavioral Health Plan / Optum: List Services: _____ List Services: _____
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**Why do you disagree with the decision?**

Explain why you disagree with Optum's action:

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**Do you want to continue benefits during the Fair Hearing process?**

- I want to continue receiving the benefit I am appealing until the authorization expires or until the hearing. I understand that my benefits will continue to whichever comes first, the expiration of the authorization or the hearing determination. I have notified my provider and I understand that if the hearing officer decides that Optum's action was correct, Optum may take action to collect the cost of those benefits *provided from the date of action forward to the date of the hearing decision* from me, as allowed by 42 CFR § 431.230(b).
- I do not want to continue receiving benefits until the hearing. If the hearing officer does not agree with Optum's action, any benefits to which I am entitled may be reinstated.

**Where can we contact you?**

Member Name	Date of birth	Medicaid ID#	
Street address	City	State	Zip code
Representative Name and Relationship to Member	Member Phone number	Representative Phone number	
Signature (participant or authorized representative)		Date	
Signature (Member signature indicating approval of above authorized representative)		Date	

Submit this form with a copy of your denial letter by one of the methods below to:

Administrative Procedures Section – Hearing Coordinator, Idaho Dept. of Health & Welfare via:

<b>Mail:</b> PO Box 83720 Boise, ID 83720-0036	<b>Fax:</b> 1-208-334-6558 <b>Phone:</b> 1-208-334-5747	<b>Deliver to:</b> 450 West State St, 10 <sup>th</sup> floor Boise, ID 83720-0036	<b>Email:</b> <a href="mailto:APS@dhw.idaho.gov">APS@dhw.idaho.gov</a>
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