Health Partners Plans
part of Jefferson

CONSENT FOR PROVIDER TO FILE A FAIR HEARING ON BEHALF OF THE MEMBER

Provider Name	**Provider Plan ID Number**
Provider Address	**Description of Specific Service or Item for which I agree the Provider Can File a Fair Hearing**
Provider Telephone Number	**Will Provider be participating with the Member?**

Name of Member	**Member's Date of Birth**
Member ID No.	
Member Mailing Address	
Member Daytime Telephone Number	**Member Evening Telephone Number**

I, **[Name of Member]**, agree that **[Name of Provider]** can request a Fair Hearing for me with **Health Partners Plans** or Department of Human Services about the service or item described above. **Note: This is only a consent for the Provider to request a Fair Hearing on behalf of the member. The member MUST attend the Fair Hearing either in person or by telephone as per the Health Choices Member Handbook.**

By signing this consent form, I understand the following:

1. I or my representative may not file a request for a Fair Hearing about the service or item listed in this consent form unless I or my representative takes back my consent for the provider to request a Fair Hearing in writing. I have the right to take back my consent at any time during the Fair Hearing process by telling **Health Partners Plans** and **[Name of Provider]** in writing that I do not want **[Name of Provider]** to continue the Fair Hearing process for me.

2. My consent to have the Provider file the request for a Fair Hearing for me will automatically no longer be in effect if the Provider does not file a request for a Fair Hearing or does not continue with the request for a Fair Hearing through the end of the request for a Fair Hearing process.

3. I or my representative has read, or has been read, this consent form, and have explained it to me until I understand it. I or my representative understands the information in this consent form.

_____ _____

Signature of Member or Representative **Date**

_____ _____

Witness Signature **Date**

_____

Print Witness Name

If the Member is unable to sign this Consent Form because the Member is legally incompetent:

_____

Name of Person Signing on Behalf of Member

_____

Address of Person Signing on Behalf of Member

_____

Relationship of Person Signing to Member

HP-880CG-7707 12/2025

Discrimination is Against the Law

Health Partners Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Health Partners Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Health Partners Plans provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Health Partners Plans provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Health Partners Plans at **1-800-553-0784 (TTY 1-877-454-8477).**

If you believe that Health Partners Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Health Partners Plans
Attn: Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
Phone: 1-800-553-0784 (TTY 1-877-454-8477)
Fax: 1-215-991-4105

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY/PA Relay 711, Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Health Partners Plans and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail, phone or email at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).
OCRMail@hhs.gov

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

January 1, 2025

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-553-0784 (TTY 1-877-454-8477) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-553-0784 (TTY 1-877-454-8477) hable con su proveedor.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-553-0784（文本电话：1-877-454-8477）或咨询您的服务提供商。

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषाकि सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-553-0784 (TTY: 1-877-454-8477) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-553-0784 (TTY: 1-877-454-8477) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-553-0784 (1-877-454-8477) أو تحدث إلى مقدم الخدمة.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-553-0784 (TTY: 1-877-454-8477) oswa pale avèk founisè w la.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-553-0784 (Người khuyết tật: 1-877-454-8477) hoặc trao đổi với người cung cấp dịch vụ của bạn.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-553-0784 (TTY: 1-877-454-8477) або зверніться до свого постачальника».

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-553-0784（TTY：1-877-454-8477）或與您的提供者討論。

ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-553-0784 (TTY: 1-877-454-8477) ou fale com seu provedor.

January 1, 2025

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসেযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-553-0784 (TTY: 1-877-454-8477) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-553-0784 (TTY : 1-877-454-8477) ou parlez à votre fournisseur.

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើនិយាយ ភាសាខ្មែរ សេវោកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវោកម្មដលែជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដលែអាចចូលប្រើរ៉ាស់បាន ក៏អាចរកបានដោយ ឥតគិតថ្លៃដែងដរែ។ ហៅទូរសព្ទទៅ 1-800-553-0784 (TTY: 1-877-454-8477) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវោរបស់អ្នក។

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-553-0784 (TTY: 1-877-454-8477)번으로 전화하거나 서비스 제공업체에 문의하십시오.

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલિરી સહાય અને ઍક્સેસિબિલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિનિ મૂલ્યે ઉપલબ્ધ છે. 1-800-553-0784 (TTY: 1-877-454-8477) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.