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 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 HealthChoices 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 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-1885

Health Partners Plans

Discrimination is Against the Law

Health Partners (Medicaid) 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 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 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 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 Member Relations at 1-800-553-0784 (TTY 1-877-454-8477).

If you believe that Health Partners 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
901 Market Street, Suite 500
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 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 or phone at:

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

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

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call: 1-800-553-0784 (TTY 1-877-454-8477).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-553-0784 (TTY 1-877-454-8477**)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-553-0784 (телетайп 1-877-454-8477**)**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-553-0784 (TTY 1-877-454-8477).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-553-0784 (TTY 1-877-454-8477).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-553-0784 (رقم هاتف الصم والبكم:1-877-454-8477).

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-553-0784 (टिटिवाइ 1-877-454-8477) ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-553-0784 (TTY 1-877-454-8477) 번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-553-0784 (TTY 1-877-454-8477)។

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposes gratuitement. Appelez le 1-800-553-0784 (ATS 1-877-454-8477).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-800-553-0784 (TTY 1-877-454-8477) သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-553-0784 (TTY 1-877-454-8477).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-553-0784 (TTY 1-877-454-8477).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-553-0784 (TTY 1-877-454-8477)।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-553-0784 (TTY 1-877-454-8477).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-553-0784 (TTY 1-877-454-8477).