NEBRASKA DHHS STATE FAIR HEARING FORM

Member Name (*please print*) _____

Member ID Number (*please print*) _____

Member Address (*please print*) _____

_____

I wish to appeal the decision made by Nebraska Total Care on my case because:

_____

_____

Member Signature

_____ Date _____

Signature of Authorized Representative

_____ Date _____

Printed Name of Authorized Representative

_____

Address of Authorized Representative if different from above

_____

Phone _____

Social Security Number _____

Name, address and phone number of your Authorized Representative for the Hearing, if any:

_____

_____

Mail the completed form to:

Legal Services- Hearing Section
PO Box 94967
Lincoln, NE 68509-4967
Phone: (402) 471-7237

The postmark showing the date you mailed your appeal will be the date of your appeal request.

****INCLUDE YOUR *NOTICE OF ADVERSE BENEFIT DETERMINATION* LETTER WITH THIS FORM****