STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

October 28, 2022

GENERAL LETTER NO. 1-E-AP-13

ISSUED BY: Iowa Medicaid

SUBJECT: Employees' Manual, Title 1, Chapter E Appendix, ***Appeals and Hearings Appendix***, Title Page, Contents page 1, and pages 1-5, revised; page 6, removed; and form 470-5526 and 470-5526(S), revised.

Summary

This chapter is revised to update 470-5526 and 470-5526(S), *Authorized Representative for Managed Care Appeals*, updating contact addresses and style and formatting throughout.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 1, Chapter E Appendix, and destroy them:

Page	Date
Title Page	February 28, 2020
Contents 1	February 28, 2020
1-6	February 28, 2020
470-5526	04/21
470-5526(S)	04/21

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 1,
Chapter E Appendix

Revised October 28, 2020

Appeals and Hearings Appendix

Page

Appeal and Request for Hearing, 470-0487 or 470-0487(S)

Purpose

Form 470-0487 is used to initiate the appeal process and to supply information needed to proceed with an appeal.

Source

Department staff may complete the English version of this form using the template in:

- SharePoint under Employee Manual/Forms, or
- The Worker Information System Exchange (WISE).

Appellants may also complete this form electronically at https://secureapp.dhs.state.ia.us/dhs_titan_public/appeals/appealrequest. The request will be submitted directly to the Appeals Section to be processed.

Print the Spanish version of this form from:

- The on-line manual, or
- SharePoint under Employee Manual/Forms.

Completion

The person wishing to appeal (the appellant) or someone acting for the appellant completes the form to initiate the appeal. The worker should assist in completing this form if the appellant wishes.

An appeal may be requested without completing this form. Any written appeal is valid. An appeal request for Food Assistance, Medicaid, Child Care Assistance, Family Planning Program or the Family Investment Program may be expressed verbally or in writing.

If the appellant requests an appeal verbally, the worker shall document the request on this form and forward to the DHS, Appeals mailbox. If an appeal request is filed in another written form, the worker shall forward the form and the written appeal request to the DHS, Appeals mailbox.

Distribution

Forward a copy of the appeal request to the DHS Appeals Section within 24 hours of receipt.

If the form is submitted to the local office, give a copy to the appellant and keep a copy in the case file.

Data

Top Section

Complete all the information, including phone number, if applicable. Check the programs under appeal.

A person requesting an attribution appeal may also request an administrative hearing. An administrative hearing is a review of the record only and does not include an appearance by the worker or client.

Indicate whether the appellant:

- Wants benefits to continue while the appeal is pending.
- Requests an interpreter for the appeal hearing.
- Requests special accomodations as the appellant is blind or hard of hearing.
- Wishes to have an informal conference to discuss the appeal. (Explain the purpose of an informal conference.)

Explain why the appellant is appealing. The explanation may be as specific as the appellant wishes to make it.

List any other persons whom the appellant wishes to have notified of the time and place of the hearing, with their addresses. This may include an attorney or representative.

The form should be signed and dated, if possible.

Authorized Representative for Managed Care Appeals, 470-5526 or 470-5526(S)

Purpose	Form 470-5526 is used to appoint an individual, organization or provider to act on the appellant's behalf during the state fair hearing process for managed care appeals. Legal documentation such as a court order establishing legal guardianship or a power of attorney can be submitted instead to designate a representative.
Source	The appellant, individual, organization or provider may print the form from the DHS website at https://dhs.iowa.gov/sites/default/files/470-5526.pdf
Completion	The Medicaid member, or their parent if the member is under the age of 18, completes and signs the Appellant Information section of the form. The individual, organization or provider acting on the appellant's behalf completes and signs the Appellant Representative Information section.
Distribution	The form shall be submitted to the managed care organization, dental carrier or the DHS Appeals Section. Addresses for each entity are provided on the form.
Data	The form contains: ▪ The appellant's name and address. ▪ A brief description of what is being appealed. ▪ The appellant's signature. ▪ The date the form was signed by the appellant. ▪ The authorized representative's name and address. ▪ The authorized representative's relationship. ▪ The authorized representative's signature. ▪ The date the form was signed by the authorized representative.

Dismissal Request, 470-5597 or 470-5597(S)

Purpose

Form 470-5597 is used to request dismissal of an appeal when the issue being appealed has been resolved. An appellant or their representative cannot ask for an appeal to be dismissed. This can only be done by the Department's representative.

An appellant or their representative can ask to have an appeal withdrawn on form 470-0492, *Request for Withdrawal of Appeal*.

Source

Department staff may complete the English version of this form using the template in:

- SharePoint under Employee Manual/Forms, or
- The Worker Information System Exchange (WISE).

Print the Spanish version of this form from:

- The on-line manual, or
- SharePoint under Employee Manual/Forms.

Completion

Complete the form and provide documentation showing the issue being appealed has been resolved.

Distribution

If the appeal has been assigned an appeal number, upload a copy of the form into the appeal record in the Appeals Information System (AIS) and use the send email feature to notify other DHS parties and the administrative law judge of the request.

If no appeal number has been assigned, forward a copy of the form to the DHS, Appeals mailbox. The Appeals Section will upload a copy of the *Dismissal Request*, once the appeal record has been established in AIS.

One copy is retained in the case record. One copy goes to the appellant.

Data

The form contains:

- The appellant's name and address.
- The appeal number.
- The requestor's name, address, and contact information.
- The requestor's signature.
- The date the form was signed.

Request for Withdrawal of Appeal, 470-0492 or 470-0492(S)

Purpose

Form 470-0492 is used to withdraw an appellant's request for an appeal and hearing. Department staff cannot ask for an appeal to be withdrawn. This can only be done by the appellant or their representative.

Department staff can ask to have an appeal dismissed on form 470-5597, *Dismissal Request*.

Source

Department staff may complete the English version of this form using the template in:

- SharePoint under Employee Manual/Forms, or
- The Worker Information System Exchange (WISE).

Appellants may complete this form electronically at https://secureapp.dhs.state.ia.us/dhs_titan_public/appeals/WithdrawalRequest. The request will be submitted directly to the Appeals Section to be processed.

Print the Spanish version of this form from:

- The on-line manual, or
- SharePoint under Employee Manual/Forms.

Completion

The worker, the Appeals Section or the appellant may prepare the form whenever an appellant indicates a wish to withdraw.

Distribution

If the appeal has been assigned an appeal number, upload a copy of the form into the appeal record in the Appeals Information System (AIS) and use the send email feature to notify other DHS parties and the administrative law judge of the request.

If no appeal number has been assigned, forward a copy of the form to the DHS, Appeals mailbox. The Appeals Section will upload a copy of the withdraw request, once the appeal record has been established in AIS.

One copy is retained in the case record. One copy goes to the appellant.

Data

The form contains:

- The appellant's name and address.
- The appeal number.
- The program being appealed.
- The date of the appeal.
- The appellant's comments, if any.
- The appellant's signature.
- The date the form was signed.

IOWA HHS

Iowa Department of Health and Human Services

Authorized Representative for Managed Care Appeals

This form shall be completed by the Medicaid member or their parent, if the member is a minor. Complete this form to appoint an individual, organization, or provider to act on your behalf during theappeals process. The member and the authorized representative must both sign this form. Legal documentation such as a court order establishing legal guardianship or a power of attorney can be submitted instead to designate a representative.

Appellant Information

First and Last Name		Date of Birth
Case Number	Medicaid ID Number	Telephone Number
Parent's Name, if appellant is minor (under age 18)		
Brief Explanation of What is Being Appealed		

By signing this form, I understand:

- This authorization is at my request. I have the right to refuse to sign this form and that it is strictlyvoluntary.
- My signature does not waive my right to represent myself.
- My signature does not waive my financial obligation should the appeal be decided in theDepartment's favor.
- I authorize my Authorized Representative to act on my behalf during my appeal and to have access to all protected health information regarding my appeal and agree that this informationmay be disclosed to other persons in connection with this appeal.
- This authorization automatically expires at the end of the appeals process or if I revoke this permission in writing. I can revoke this authorization by sending a written request by mail or faxto: Department of Human Services, Appeals Section, 1305 E Walnut Street 5th Floor, Des Moines, IA 50319 Fax: (515) 564-4044.

Signature of Appellant or Parent, if appellant is minor	Date Signed

Appellant Representative Information

Authorized Representative First and Last Name		
Organization or Provider Business Name		
Representative Mailing Address		
City	State	ZIP Code
Relationship to Representative	Representative Telephone Number	

By signing this form, the Authorized Representative understands:

As a condition of serving as an authorized representative, I agree to abide by relevant state andfederal laws concerning conflicts of interest and confidentiality of information.

If the appellant is physically unable to sign, I, the Authorized Representative, certify that (appellant) _____ is physically unable to sign this form. Describe the physical incapacity affecting the appellant.

_____

_____

_____

Signature of Authorized Representative	Date Signed

NOTE: This form is not valid for appellants who are mentally unable to sign. If the appellant is mentally unable to sign this form, the person acting on their behalf must submit legal proof of guardianship with the appeal.

Please submit the form to your managed care organization or to the Department of Human Services at the address below.

Amerigroup Iowa Inc Grievances and Appeals Department 4800 Westown Pkwy Ste 200 West Des Moines, IA 50266		Iowa Total Care Member Services 1080 Jordan Creek Pkwy, Ste 100S West Des Moines, IA 50266 FAX: (833) 847-3026
Delta Dental of Iowa Attn: DWP Appeals and Complaints PO Box 9040 Johnston, IA 50131-9040	MCNA Dental Attn: Grievances and Appeals Department 200 West Cypress Creek Road, Suite 500 Fort Lauderdale, FL 33309	Department of Human Services Appeals Section 1305 E Walnut St 5th Floor Des Moines, IA 50319 FAX: (515) 564-4044 Email: appeals@dhs.state.ia.us

IOWA HHS

Iowa Department of Health and Human Services

Representante autorizado para apelaciones de cuidado administrado

(Authorized Representative for Managed Care Appeals)

Este formulario debe ser completado por el miembro de Medicaid o uno de sus padres en caso de que el miembro sea menor de edad. Complete este formulario para designar a una persona, organización o proveedor para que actúe en su nombre durante el proceso de apelación. Este formulario debe ser firmado por el miembro y el representante autorizado. En lugar de este formulario puede presentar documentación legal, como una orden judicial o poder notarial, que establezca la tutela legal.

Información del apelante

Nombre y apellido		Fecha de nacimiento
Número de caso	Número de identificación de Medicaid	Número de teléfono
Nombre del padre/madre si el apelante es menor (menos de 18 años)		
Breve explicación del asunto que se apela		

Al firmar este formulario, entiendo que:

- Esta autorización se entrega conforme a mi solicitud. Tengo derecho a no firmar este formulario, esto es estrictamente voluntario.
- Firmar este documento no implica renunciar a mi derecho a representarme yo mismo.
- Firmar este documento no implica renunciar a mis responsabilidades financieras si la apelación se resuelve a favor del Departamento.
- Autorizo a mi Representante Autorizado a actuar en mi nombre durante mi apelación y a tener acceso a toda la información médica protegida relacionada con mi apelación, también acepto que esta información puede ser divulgada a otras personas relacionadas con esta apelación.
- Esta autorización caducará automáticamente cuando finalice el proceso de apelación o si la revoco por escrito. Puedo revocar esta autorización enviando una solicitud por escrito vía correo postal o fax a: Department of Human Services, Appeals Section, 1305 E Walnut Street 5th Floor, Des Moines, IA 50319 Fax: (515) 564-4044.

Firma del apelante o de uno de los padres, si el apelante es menor de edad	Fecha de la firma

Información del representante del apelante

Nombre y apellido del representante autorizado		
Organización o nombre comercial del proveedor		
Dirección postal del representante		
Ciudad	Estado	Código postal
Relación con el representante	Número de teléfono del representante	

Al firmar este formulario, el Representante autorizado entiende que:

Como condición para servir como representante autorizado, acepto cumplir con las leyes estatales y federales pertinentes a conflictos de intereses y confidencialidad de la información.

En caso de que el apelante no pueda firmar físicamente, yo, el Representante Autorizado, certifico que el apelante se encuentra _____ físicamente imposibilitado para firmar este formulario. Describa la incapacidad física que afecta al apelante.

_____

_____

_____

Firma del Representante Autorizado	Fecha de la firma

Nota: Este formulario no es válido para apelantes que se encuentren mentalmente imposibilitados para firmar. Si el apelante se encuentra mentalmente imposibilitado para firmar este formulario, la persona que actúe en su nombre debe presentar una prueba válida de la tutela legal junto con la apelación.

Envíe el formulario a su organización de cuidado administrado o al Department of Human Services a la dirección que figura a continuación.

Amerigroup Iowa Inc Grievances and Appeals Department 4800 Westown Pkwy Ste 200 West Des Moines, IA 50266		Iowa Total Care Member Services 1080 Jordan Creek Pkwy, Ste 100S West Des Moines, IA 50266 FAX: (833) 847-3026
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