IOWA Health and Human Services

Appeal and Request for Hearing

Instructions

This form gives us the information needed to help you with your appeal. Please fill out each part of this form. Describe the issue(s) in as much detail as possible.

NOTE: If you do not agree with a decision made by your Managed Care Plan (MCP) or Dental Plan, you must complete the first level appeal through the plan. If you have not done this, stop right here. Contact your MCP or Dental Plan to start the correct process.

You can have someone else file your appeal for you with your written consent. This person is called an Authorized Representative. Your Authorized Representative can be your provider, a relative, a friend or even an attorney.

If you are a legal guardian or Power of Attorney filing an appeal for someone else, please send documentation showing this.

You must submit your appeal within the required time frame, or you may lose your right to appeal. The written notice you received will provide more information about the time frame to appeal.

How To Submit an Appeal

There are multiple ways to submit an appeal. Choose the one that works for you:

Online: Appeal online through the Department of Health and Human Services (HHS) website at https://hhs.iowa.gov/appeals or by using this QR code.

Email, Fax or Mail: Fill out the form offline or write us a letter and submit by:

- Email: appeals@hhs.iowa.gov
- FAX: (515) 564-4044
- Mail: Iowa Department of Health and Human Services, Appeals Bureau,
  321 E 12th Street
  Des Moines, Iowa 50319

In Person: Take this form or a written request to your local HHS office.

Verbal (if allowed): Some programs allow you to appeal verbally. We can help you complete your appeal request. Please call the HHS Appeals Bureau 1-888-723-9637 or your local HHS office and a team member will assist you.

How To Submit Information

If you submit this form online and want to include documents (for example, medical records or a note for your doctor) for your appeal, send them by email to appeals@hhs.iowa.gov. You may also fax or mail the information using the contact information above. When you send documents, tell us that you filed an appeal online.

After Appeal Is Submitted

We will let you know in writing that we received your appeal.

We now offer online access to your appeal documents! You will get instructions on how to create a MyIowaAccess portal account in the mail.

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Appeal and Request for Hearing

Who Is Requesting This Appeal?

☐ Self ☐ Family Member ☐ Someone else

Friends or family cannot represent you for a child abuse or adult abuse appeal. Only an attorney can help you with this.

If you are a legal guardian or Power of Attorney filing an appeal for someone else, please send documentation showing this.

First Name	Middle Initial	Last Name
Agency or Business Name, if applicable		
Mailing Address (include Apt, Unit or Lot Number, if applicable)		
City	State	Zip Code
Phone Number	Email Address	

Who Is the Appeal For?

First Name	Middle Initial	Last Name
Mailing Address (include Apt, Unit or Lot Number, if applicable)		
City	State	Zip Code
County of Residence		Date of Birth
Case Number	Prior Authorization Number (Managed Care Plan or Dental Plan)	
Phone Number	Email Address	

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What Are You Appealing? (Select all that apply)

☐ Adoption Licensing	☐ Adult Abuse	☐ Cash Assistance
☐ Cannabis Regulation	☐ Child Abuse	☐ Child Support
☐ Child Care Assistance	☐ Child Care Registration (Providers)	☐ Dental Plan Decision*
☐ Foster Care Licensing	☐ Managed Care Plan Decision*	☐ Medical Assistance
☐ Office of Public Guardian	☐ Overpayment	☐ PROMISE JOBS
☐ Record Check Evaluation	☐ Rent Reimbursement	☐ SNAP Assistance
☐ Student Abuse	☐ WIC	

Other: _____

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Tell us why you are appealing (1000-character limit):

Continuation of Benefits

You **may** be able to keep getting your benefits at the same rate as you have now until a decision is made in the appeal. **If you lose your appeal, you may have to pay back some or all the benefits you received during the appeal process.**

Do you want your benefits or services to continue? ☐ Yes ☐ No

Contact your worker if you have questions about when benefits can continue.

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Additional Information

Do you want to have a conversation with your worker about this matter? (This is an informal conference) ☐ Yes ☐ No

Do you need help with your appeal because you are blind or hard of hearing? ☐ Yes ☐ No

Tell us how we can help: _____

Do you want a language interpreter for your hearing? ☐ Yes ☐ No

If yes, what language? _____

Signature of Person Who Filled Out This Form	Date