Otero County Healthcare services
Appeal Form

APPEAL REQUEST FORM INSTRUCTIONS:

If you applied for Healthcare Assistance from Otero County, NM and were denied in whole or in part, or county assistance from the fund is denied, modified, or terminated, a written request for a hearing must be sent to the Claims Administrator.

TIME LIMITS:

You have thirty (30) days since fund denial, or fund assistance modification, or fund assistance termination to submit the Appeal Form. Failure to timely submit a written request for hearing shall result in the denial, modification, or termination being deemed final.

PROCESS:

The Claims Administrator shall schedule the appeal for reconsideration by the Health Care Board or the Board of County Commissioners. If the applicant remains dissatisfied with Board action on reconsideration, the applicant shall request a second hearing, in writing, **within 15 days** of the meeting at which the matter was reconsidered. The Administrator shall schedule a hearing before a hearing officer within 30 days. The hearing shall be conducted by a hearing officer appointed by the County Administrator. Within five days of the hearing, the hearing officer shall render a written decision, by findings of jurisdiction and facts. (§140-15(A)-(E))

AUTHORIZED REPRESENTATIVE:

You have the right to choose an authorized representative to help you with your appeal. This is a trusted person (counsel, family member, or other representative) who has your permission to talk with us about your appeal, see your information, and act for you on matters related to your appeal, including getting information about you and signing your appeal request on your behalf.

JUDICIAL REVIEW:

Any ambulance service, health care provider, or patient who is aggrieved by a decision of the Board may seek judicial review of the decision pursuant to NMRA, Rule 1-074.

PRIVACY AND USE OF INFORMATION:

Healthcare Services and the Board protects the privacy and security of information about you that you've provided. We do not share or make public any private information protected by Federal, State, or Local law.

Otero County Healthcare Assistance
1101 New York Avenue
Alamogordo, NM 88310

HEALTHCARE REVIEW SERVICES

Otero County Healthcare Assistance Appeal Form

OTERO COUNTY, NEW MEXICO

The purpose of this form is to assist you in filing an appeal with Otero County Healthcare Services regarding the Healthcare Assistance program. You are not required to use this form to file an appeal; a letter with the same information is sufficient. However, if you file an appeal by letter, you should include the same information that is requested in the form.

COMPLAINANT INFORMATION				
Name (Last, First Middle):			Date of Birth:	
Street Address	City	County	State	Zip
If your mailing address is different, please fill it in below. If not, please leave blank.				
Street Address or P.O. Box	City	County	State	Zip
Email Address:	Telephone Number:	Do you prefer email correspondence? ☐Yes ☐No		

Authorized Representative or Guardian
The authorized representative may or may not be the same individual designated as an authorized representative for the application processing or for meeting reporting requirements.

Name of Authorized Person(s)	Mailing Address	Telephone Number	Relationship	Email Address

APPEAL		
What is the Notification of Status letter date?(optional)	How much was the denial? (optional)	What is the Claim Number? (printed on the Status letter labeled as "Clm")(optional)
Did you meet income criteria? ☐Yes ☐No	If you did not meet the income criteria but believe you should have met the criteria or should have special consideration, please explain.	
Did you meet residency criteria? ☐Yes ☐No	If you did not meet the residency criteria but believe you should have met the criteria or should have special consideration, please explain.	
Did you meet 75 day filing criteria? ☐Yes ☐No	If you did not meet the 75 day filing criteria but believe you should have met the criteria or should have special consideration, please explain.	
Did you receive services with one of the Contracted Providers? ☐Yes ☐No		
If you answered "yes" to any of the above questions, please provide any supporting documentation.		

Please provide a detailed explanation about why you are requesting this appeal. You may use extra paper if necessary.

EXPEDITED APPEAL.
If you have an immediate need for health services, and a delay could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, you can ask for an expedited (faster) appeal review. Please explain your reason for the request in the space below.

☐ **I need an expedited appeal.**

Release of Information:

During your appeal, we may need to share with you or your authorized representative the information Otero County's Healthcare Services Department used to determine your eligibility. This information might include employment income information from a consumer reporting agency, information about income you receive from the Social Security Administration, and federal tax information from the Internal Revenue Service about members of your household, including information from your last filed federal income tax return. Otero County cannot share federal income tax information or monthly and annual Social Security Benefit information under Title II of the Social Security Act from the Social Security Administration to an authorized representative or other individuals without your consent. Sign below to give your consent.

_____Signature

I understand by completing, signing, and dating below, I authorize Otero County Healthcare Services to disclose to the individuals whose signatures are provided below as well as any authorized representative any federal tax information in my eligibility record. I also consent to the release by Otero County Healthcare Services of my monthly and annual Social Security Benefit information under Title II of the Social Security Act to these same individuals along with other information in my Healthcare Assistance eligibility record, collected based on the application I filled out (or was completed for me) or that listed me as a household member, and from other data sources like income and employment verification from a consumer reporting agency that were used to make eligibility determination.

I understand I can request a copy of my Healthcare Assistance eligibility appeal record during the appeals process.

Each adult member of the household must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

The authorization is valid until the earlier of:

- The resolution of the appeal; or
- My written notification that I want any or all of my authorized representatives removed from this appeal.

I'm signing this form under penalty of perjury, which means I've provided true answers to all the questions, and I've answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

Signature	Printed Name	Date
Signature	Printed Name	Date

Mail To:
Claims Administrator
Healthcare Services
1101 New York Avenue
Alamogordo, NM 88310