THE AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)
FAIR HEARING REQUEST

MAIL TO: Agency for Health Care Administration 2727 Manhan Drive Tallahasee, FL 32309	**FAX:** 1- 239-338-2641 **Email:** MedicaidHearingUnit@ahca.myflorida.com **Call:** 1-877-254-1055

Who is Requesting a Hearing?	Name:	Date of Birth:	Phone:
	Address:		
Authorized Representative (if any)	Name:	Representative Signature:	
	Relationship:	Phone:	
Translator	☐ YES ☐ NO	Language Needed:	
Insurance Company:	Name:	Phone:	
Denied Service:	Date of Decision to Deny:	Claim/Authorization Number:	

I WANT A FAIR HEARING. MY PLANS DECISION IS WRONG BECAUSE:

Claimant Signature: **Date:**