DISABILITY RIGHTS NEW JERSEY

ADVANCING JUSTICE. ADVOCATING INCLUSION.

Form Letter to Request Fair Hearing

INSTRUCTIONS:

Use this form if you have been notified that your Medicaid coverage is being terminated because you are no longer eligible.

If you disagree with this notice, you should request a fair hearing. You can request a fair hearing in writing by

1. Mailing:

   State of New Jersey,
   Division of Medical Assistance and Health Services
   Fair Hearing Unit
   P.O. Box 712
   Trenton, NJ 08625-0712

2. Faxing the request with a copy of the entire denial notice to:
   1-609-588-2435

Keep a copy of your request and proof you submitted it such as a fax confirmation receipt or mail tracking receipt.

For terminations dated between April 1, 2023 and April 1, 2024, you have **60 days** to request the fair hearing (from the date on the termination notice), but you should make the request as soon as possible. If you request a fair hearing on time, coverage will continue during your appeal.

You have the right to an interpreter for the Medicaid Fair Hearing. You can request an interpreter be provided or you can bring your own.

RIGHT TO REPRESENTATION:

You have the right to represent yourself, have someone else represent you, or have legal representation. If you would like legal representation and are not able to pay for it, you can contact one of the following:

- Legal Services of New Jersey at www.LSNJLawHotline.org or call Legal Services of New Jersey at 1-888-576-5529;
- Disability Rights New Jersey (DRNJ) at advocate@disabilityrightsnj.org or call DRNJ at 1-800-922-7233 (TTY: 711) for free legal and advocacy services for people with disabilities; or
- Community Health Law Project (CHLP) at chlpinfo@chlp.org or call CHLP at 1-(973) 275-1175 to be directed to the appropriate office serving your county. A list of CHLP offices can also be found at www.chlp.org.

Interpreters are available if you are disabled or LEP (Limited English Proficient).

Your Name: _____

Your Home Address: _____
_____
_____
_____

Your date of birth _____
Your phone # _____ Date _____

I received a termination notice on _____ (date).
I received my notice: __ by phone __ by mail __by email __ by fax. ___other (please specify how you found out):

_____

I would like to request a Medicaid Fair Hearing because I do not agree with the decision to terminate my Medicaid coverage. I believe I am still eligible for Medicaid. I want my Medicaid eligibility to continue during the appeal.

I am requesting an interpreter for the Medicaid Fair Hearing in the following language:

_____