IDAHO DEPARTMENT OF HEALTH & WELFARE

Contact Information for the Idaho Behavioral Health Plan Governance Bureau	
Mail:	IBHP Governance Bureau PO Box 83720, Boise, ID 83720-0009
Phone:	866-681-7062
Fax:	208-364-1811
Email:	IBHPAppeals@dhw.idaho.gov

Your Appeal Rights

Have your Idaho Behavioral Health Plan (IBHP) benefits or services been denied, changed, or not acted upon with reasonable promptness? If so, and you do not agree with the decision, you can submit an appeal. An appeal asks for a fair hearing to dispute the decision about your benefits or services. To submit an appeal asking for a fair hearing, read the "Appeal Rights and Procedures" section below. If you have questions about the decision or appeal process, contact the Department of Health and Welfare's IBHP Governance Bureau.

Important Note: If you have Medicaid, your eligibility for Medicaid was determined by the Division of Self Reliance. If your benefits have been terminated because you are no longer eligible, you must appeal that decision through the Idaho Department of Health and Welfare's Division of Self Reliance.

Appeal Rights and Procedures

How long do I have to request an appeal?

You need to submit an appeal requesting a fair hearing within **one hundred and twenty (120) days** of the appeal determination by Magellan. There are two kinds of appeals: standard or expedited (fast).

What is a standard appeal?

In a standard appeal, the IBHP Governance Bureau has ninety (90) days from the date the appeal is received to process an appeal and conduct a hearing. They will contact you if more information or time is needed to process the appeal.

What is an expedited (fast) appeal?

You should request an expedited (fast) appeal if waiting up to ninety (90) days for a final decision will jeopardize your: life, physical or mental health, or your ability to attain, maintain, or regain maximum function.

In your appeal, explain why you need an expedited appeal and, if possible, send a letter or records from your medical provider supporting your request. Idaho Medicaid will contact you if more information or time is needed.

Idaho Medicaid will send you written notice within three (3) working days from the date the appeal was received to provide a decision on whether you meet the criteria for an expedited appeal. 42 CRF § 431.244(f)(2). If Idaho Medicaid determines an expedited appeal is not necessary, the hearing will be conducted as a standard appeal.

If you have questions about expedited appeals, contact the IBHP Governance Bureau at 866-681-7062.

How do I request an appeal and fair hearing?

A request to appeal and for a fair hearing can be mailed, delivered, emailed, or made by telephone. If you appeal by telephone, it is good practice to also submit a written request to show when you requested your appeal. If possible, please send a copy of the notice you received that includes the decision being appealed. You can use the Appeal Request Form (attached) or write a letter that includes:

- Name of person appealing
- The address and telephone number of the person appealing
- The reasons why you are requesting the appeal and fair hearing
- Whether you are requesting standard or expedited (fast) appeal
- Whether you are requesting the continuation of benefits and services (if you are on Medicaid)

What should I send with my appeal request?

You can send medical records, doctor's notes, or financial records which support the reasons for your appeal. Keep copies of any documents you send. **You do not have to send supporting documentation to submit your appeal.**

You have the right to request all documents used by the division to make the decision and copies of all documents in your case file and electronic account. 42 CFR § 431.242(a)(1).

You must be given a reasonable amount of time to review these documents before the hearing.

How to request the continuation of benefits and services?

If you are getting the services or benefits through Medicaid now, and you request a hearing within 10 days of receiving this notice or before the date your services will end (whichever is later), then you may request to continue receiving the services throughout the appeal process. If the decision does not change then you may be responsible for the cost of any extra services provided. 42 CFR § 431.230 and 42 CFR § 438.420.

Your Right to an Independent Medical Assessment.

If your appeal goes to a State Fair Hearing and the hearing officer thinks it is necessary to have a medical assessment from someone other than the person or people who made the original decision, then a medical assessment must be done and made part of the record. The medical assessment must be paid for by Idaho Medicaid. 42 CFR § 431.240(b).

What happens at a State Fair Hearing?

Idaho Medicaid may try to informally settle the appeal with you before the fair hearing. If the appeal cannot be informally settled, it will be scheduled for a Fair Hearing with the Office of Administrative Hearings.

A Hearing Officer will conduct a telephonic with you, any witnesses you bring, and Idaho Medicaid and their witnesses. At the fair hearing you may testify and call witnesses to establish facts, question any Medicaid witnesses or evidence, and present documents that support your position. See 42 CFR § 431.242(b)-(e).

The Hearing Officer will decide the appeal based upon the evidence and witness testimony presented during the fair hearing. It may take up to thirty (30) days after the hearing to make a decision. An expedited appeal will be decided sooner.

Other Details

Authorized Representative

With your permission, a relative, friend, advocate, doctor, or lawyer can file an appeal or speak for you during the appeal.

Use a letter, email, or the appeal form to notify the division if you have an Authorized Representative so they can receive information regarding the appeal.

Legal and Other Accommodations Help

Legal Aid Services may be available to assist with your appeal. Contact Legal Aid Services at 208-746-7541.

Free Services Available

The Medicaid division offers free services to you. This includes forms or information in other formats or languages, interpreter services, and accommodations for disabilities. To get more details or get these services, please call 208-334-5747.

Participant Non-Discrimination Notice

The Medicaid division complies with federal and state civil rights laws. This means the division will not treat anyone differently because of age, race, color, national origin, gender, religion, political benefits, disability, or sexual orientation. You can file a complaint with the Office of Civil Rights if you believe the division treats you differently for any of these reasons.

Information about Appeals for Youth Empowerment Services (YES)

Visit the Appeals webpage on the YES website for Frequently Asked Questions and other resources. https://yes.idaho.gov/appeals/

Reference

Medicaid Regulations on appeal rights and process can be found in 42 CFR § 431.200 and 42 CFR § 438.400-424.

https://www.ecfr.gov/current/title-42/part-431
https://www.ecfr.gov/current/title-42/part-438/subpart-F

Interpretation Services

English	ATTENTION: Language assistance services, free of charge, are available to you. 1-800-926-2588 (TTY: 1-208-332-7205).
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-926-2588 (TTY: 1-208-332-7205).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-926-2588（TTY：1-208-332-7205）。
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-926-2588 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-208-332-7205).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-926-2588 (TTY: 1-208-332-7205)번으로 전화해 주십시오.
नेपाली (Nepali)	ध्यान दिनुहोस्: तपाईंले नेपाली ब?ोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उप?लब्ध छ । फोन गर्नुहोस् 1-800-926-2588 (टिटिवाइ: 1-208-332-7205) ।
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-926-2588 (TTY: 1-208-332-7205).
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-926-2588 (رقم هاتف الصم والبكم: 1-208-332-7205).
Tagalog (Tagalog/ Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-926-2588 (TTY: 1-208-332-7205).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-926-2588 (телетайп: 1-208-332-7205).
Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-926-2588 (TTY: 1-208-332-7205).
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-926-2588（TTY:1-208-332-7205）まで、お電話にてご連絡ください。
Română (Romanian)	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-926-2588 (TTY: 1-208-332-7205).
Ikirundi (Bantu-Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-926-2588 (TTY: 1-208-332-7205).
فارسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرید تماس 1-800-926-2588 (TTY: 1-208-332-7205) می باشد.
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-926-2588 (TTY: 1-208-332-7205).

Appeal Request Form

Directions: Fill out the form, sign, and send it to us. Send a copy of the notice and any other details.

Section 1: Tell us about the person who needs this appeal. (required)

Name:	Medicaid #:	Date of Birth:
Address:		
Email:		Phone:

I want to receive updates or notices by (choose one): ☐ Email ☐ Mail ☐ Phone

Section 2: What are you appealing? What action(s) are you requesting? (required)

Tell us why you are requesting an appeal. Use extra paper or the back of form if you run out of room.

Section 3: Are you asking for a standard or expedited (fast) appeal? (choose one)

☐ I am asking for a standard appeal.

Remember: Send your request within **one hundred and twenty (120) days** of the date of the appeal determination by Magellan.

☐ I am asking for an expedited (fast) appeal.

Remember: This type of appeal is necessary if your life, health, or ability to attain, maintain, or regain maximum function is in danger.

Send your request within **one hundred and twenty (120) days** of the date of the appeal determination by Magellan. If possible, include a note from your medical provider telling us why you can't wait for a standard appeal. If you don't qualify, we'll review it as a standard appeal.

Section 4: What else should we know? (optional)

Authorized Representative

☐ I want and approve that someone else speak or represent me in my appeal.

Name/Organization:	
Address:	
Email:	Phone:
Signature of representative:	Lawyer? ☐ Yes ☐ No

Special Accommodations

☐ I need an interpreter. Language (and dialect):

☐ I need other accommodations. Please list:

☐ I read the *continuation of services or benefits* section and want to continue my service or benefits.

Section 5: Signature (required)

Signature:

If someone helped you fill out the form, they need to sign below:

Name (print) Relationship/Organization Signature Date

Send by:

Email
IBHPAppeals@dhw.idaho.gov

Fax
208-364-1811

In-Person
Local DHW Offices

Mail
IBHP Appeals
PO Box 83720
Boise ID 83720-0009