Amerigroup
An Anthem Company

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STATE FAIR HEARING REQUEST FORM

Please complete this form and send it to the address below if you would like to ask for a state fair hearing. You must send your request within 120 days of the date on your appeal decision letter.

Fair Hearing Coordinator
Amerigroup
5959 Corporate Drive, Suite 1300
Houston, TX 77036

Member Name	Parent/Guardian Name (if member is a child)
Amerigroup ID #	Medicaid ID #
Member Address	Member Phone #
Reference or appeal number from letter	Date of Appeal Decision Letter
Please describe the service(s) denied, reduced or changed	

Yes, I would like to request a state fair hearing from the Texas Health and Human Services Commission. I have completed the Amerigroup appeal process and received an appeal decision letter.

Fill in the space below if you'd like someone to act on your behalf for the state fair hearing.

I authorize _____ to represent me/my child for the fair hearing.

Check the box below if you'd like to keep getting your current services during your fair hearing.

☐ I am sending my request within 10 days of when Amerigroup sent the appeal decision letter to me. My appeal was about services I am still receiving and I want the services to continue during my fair hearing.

_____ _____

Member Signature **Date**