DEPARTMENT OF HEALTH
PUERTO RICO MEDICAID PROGRAM

☐ Appeal
☐ Expedited Appeal

APPEAL REQUEST
(BY HEARING)

APPELLANT'S INFORMATION

Name:

Postal address:

Telephone: Email:

BASIS FOR APPEAL

1. Upon receipt of the Notice of Decision-Renewal of Benefits of the Medicaid program, I exercise the right to request an Appeal, through a Hearing, for differing with the determination of the Program for the following reasons:

2. The evaluation in review of the following persons is requested:
   a.
   b.
   c.
   d.
   e.

3. Comment and/or special circumstances about any of the applicants

4. Justification for Requesting Expedited Appeal:

I certify that: I have been informed and warned and understand in full knowledge, about the adverse legal implications that I would face of providing false information at the time of signing this document.

Name of Appellant	Appellant's Signature	Date

- The determination of whether the appeal is expeditiously resolved rests with the decision of the Appeals Officer. If the Appeals Officer determines that you do not meet the criteria necessary to be processed expeditiously, your appeal will be attended on a regular schedule. The expedited appeal must be resolved within seven days of its filing.

OFFICIAL USE LOCAL OFFICE

This document was received on _____ (day) of _____ (month) of _____ (year) road:

- ☐ personal delivery, in the Local Office of the Municipality _____,
- ☐ email
- ☐ Postal mail
- ☐ fax

The following supporting documentation is included:

Name of Official	Date
Signature of the Official	Date

Once this document has been submitted to the Local Office, it must be sent to the Office of Appeals of the Medicaid Program within a period not exceeding **three (3) days**.