Sample Appeal Letter for Medical Assistance

You must file a notice of appeal with the Minnesota Department of Human Services (DHS) within 30 days of the date you received the denial. You can use the appeal form available on the DHS website at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG, or you can send a letter to the Appeals Division at DHS. You can also fax the appeal letter to the Appeals Division at: 651-431-7523. Here is a sample letter to help you write your appeal letter:

Date: _____________

Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

Dear Appeals Office:

I am appealing the denial of prior authorization for a (name the assistive technology).

I live in (name of county) in the State of Minnesota.

Medical Assistance sent me a notice telling me authorization was denied. The date on the notice is (date). I received the notice on (date). A copy of the notice I received is included with this letter.

I want to have an (in-person or telephone) hearing to appeal this denial.

Signed,

____

____
Your name

____
Address

____
City/State/Zip

____
Phone Number

____
Email Address (if you have one)

Getting Help with the Cost of an Appeal

You have a right to a free copy of all papers in the case file for the hearing. However, you may have to pay some other costs. The county must reimburse you for any necessary and reasonable costs you have to appeal your case. This might include things like transportation, child care, and making copies of papers. If you have any of these costs, complete this form and give it to your case manager or financial worker. Be sure to include copies of any receipts or papers that show what you paid.

Request for Hearing Costs

____
Name

____
Address

____
City/State/Zip Code

____
Phone

____
Email

To:______________________________ County:____________________________

I had a fair hearing at the Minnesota Department of Human Services on (date).
The Docket Number for the appeal is (Docket Number).

Minnesota Statutes section 256.045 requires the county agency to reimburse me the following costs:

			Receipt Attached
Transportation	Bus	$__________________________	______
	Mileage	$__________________________	______
	Parking	$__________________________	______
Child Care		$__________________________	______
Photocopies		$__________________________	______
Medical Assessment		$__________________________	______
Witness Fee ($25 per witness)		$__________________________	______
Other reasonable costs		$__________________________	______

I verify that these costs are correct and were incurred for my appeal at the Minnesota Department of Human Services.

Signature: ____
Date: ____