



UNDERSTANDING THE FIRST LEVEL REVIEW PROCESS

You have the right to ask the Department of Health and Human Services (DHHS) to hold an internal first level review followed by an external second level review of a decision to delay, deny, reduce, terminate, or suspend your child's Health Choice services. Both reviews must be completed within 90 calendar days of the date of receipt of the internal first level review request.

If your child's physician determines that the standard 90 day time frame could seriously jeopardize your child's life or health or ability to attain, maintain, or regain maximum function, you may request that the reviews be completed within an expedited time frame. Each level of expedited review must be completed within 72 hours unless you request additional time (no more than 14 days may be allowed).

If you wish to request a review, complete this form and mail or fax it to:

NC Health Choice
Review Coordinator
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
FAX: (919) 733-6608

Your request for an internal first level review must be received within 30 days of the date of the decision letter.

The internal first level review is held by the Clinical Medical Director of the Division of Medical Assistance or clinical designee who will review the decision and any other information **you submit with the internal first level review request**. You may review the Health Choice case file and the documents used to make the adverse decision at any time by contacting the Health Choice Review Coordinator at 919-855-4100.

If the decision is a reduction, suspension, termination, or a denied request for increase of a service your child already receives, even if you request review, the services will be covered at the level stated in the decision under review, and services which are terminated or suspended services shall not be covered, unless and until the decision is overturned on review.

Your child will remain enrolled in the Health Choice program during the review process as long as he or she is eligible.



**INTERNAL FIRST LEVEL REVIEW REQUEST
FORM**

THIS FORM MUST BE SUBMITTED WITHIN 30 DAYS OF NOTICE DATE.

MEMBER INFORMATION:		
NAME:		NCHC ID:
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REPRESENTATIVE (PARENT/GUARDIAN INFORMATION):		
NAME:		RELATIONSHIP:
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME: ()	WORK: ()	
SERVICE AND PROVIDER INFORMATION		
SERVICE:		DATE OF SERVICE:
PROVIDER NAME:		CONTACT PERSON:
TELEPHONE: ()		FAX: ()
REPRESENTATION AT THE REVIEW: If you have a lawyer or other representative you would like to assist you in the review process, please write their name and contact information below.		
<input type="checkbox"/> I WILL REPRESENT MY CHILD.		<input type="checkbox"/> I WANT SOMEONE ELSE TO REPRESENT MY CHILD
By signing this document, I authorize the following person to represent the above recipient, and I authorize the Division of Medical Assistance to release to the following person any and all medical records, other documents, and confidential information which may pertain to the review of this decision.		
NAME:		TELEPHONE: ()
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REASON FOR REVIEW REQUEST		
WHY DO YOU DISAGREE WITH THE DECISION? You may include documentation from your child's physician or others. Include the Explanation of Benefits (EOB) or letter about the benefit decision.		
Additional documentation included: YES <input type="checkbox"/> NO <input type="checkbox"/>		
EXPEDITED REVIEW		
NEED EXPEDITED REVIEW:	<input type="checkbox"/> YES (Include physician documentation)	<input type="checkbox"/> NO
SUBMIT FORM TO: NC Health Choice-DMA-Directors Office 2501 Mail Service Center Raleigh, North Carolina 27699-2501 Fax: (919) 733-6608		
SIGNATURE:		DATE: