

Appeals Rights and Deadlines

You have a right to a hearing if you disagree with a decision we have made. You have 30 days from the date you receive this letter to request an appeal. If you do not request an appeal, you may lose the right to a hearing. Please see the enclosed appeal form for complete instructions.

After completing Sections I and II on the enclosed form,

Please **MAIL** to:

EOHHS/ Medicare-Medicaid Plan [This address is for mail only.]
Hazard Building LL B23, 74 West Road
Cranston, RI 02920-8409

Or **FAX** to: (401) 462-3158

If you need help in person or to hand deliver your appeals form, please go to a local Rhode Island Department of Human Services (DHS) Office. If you have questions about completing the form or locating a DHS Office, please call the Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469 (TTY 711), Monday- Friday, 8:30 am- 7:00 pm, Saturday 9:00 am- 12 noon.

Thank you for your attention to this matter.

[Insert appeals form here]

[<Marketing Material ID: 016 NOTICE TO CONFIRM VOLUNTARY
DISENROLLMENT>]