ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437

501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers**

DATE: **February 1, 2010**

SUBJECT: **Section V Provider Manual Update Transmittal**

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REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
—	—	DMS-840	2-1-10
Section V text	Blank	Section V text	Blank

Explanation of Updates

Form DMS-NOA, NOTICE OF APPEAL has been renamed to DMS-840, Request for Appeal. This form, used by the Office of Appeals and Hearings, has also been updated for clarification purposes.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Marilyn Strickland, Assistant Director

Add to following section:

Arkansas Medicaid Forms

Request for Appeal	DMS-840

Add to following section:

In order by form number:

DMS-840

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
REQUEST FOR APPEAL

I want to appeal the attached denial of services. I understand that the Office of Appeals and Hearings must receive this notice within thirty-five (35) calendar days of the date of the attached denial letter.

Please check one of the following:

☐ I was not receiving services on the date of this denial, but would like to appeal this decision.

☐ I was receiving services on the date of this denial and would like those services to continue unchanged until after my appeal is decided. I understand that to have my services continue at the same level until my appeal I must request this hearing within ten (10) calendar days from the date of the denial letter. I understand that if I lose the appeal I will be responsible for the cost of the services that were denied.

☐ I was receiving services on the date of this denial and agree to receive services at the level approved in this decision until my appeal is decided.

_____ _____
Beneficiary's Name Beneficiary's Medicaid ID Number

_____ _____
Signature of Beneficiary Beneficiary's Social Security Number
(If beneficiary is under the age of 18 Signature of Parent or Guardian)

_____ _____
Parent/Guardian Name Telephone Number

_____
Parent/Guardian Signature

Send your request to:
Office of Appeals and Hearings
PO Box 1437, Slot N401
Little Rock AR 72203-1437

_____

If you disagree with our decision, you may ask for an appeal from the Office of Appeals and Hearings. To ask for a hearing you must send your request in writing within 35 calendar days to P.O. Box 1437, Slot N401, Little Rock, AR 72203-1437. You must enclose a copy of the denial letter and a copy of the envelope containing that letter or enclose a copy of that letter showing the facsimile transmission confirmation with your request. If you do not include those copies your appeal will be delayed. All deadlines run from the next business day after the postmark on the envelope containing that letter or the next business day after the date on the facsimile transmission confirmation.