

## APPEAL FORM

I want to appeal.

Name of Medicaid Recipient appealing \_\_\_\_\_

Social Security Number of Medicaid Recipient \_\_\_\_\_

Describe Items or Services requested (or enclose copy of denial notice):

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Submit form to:**

Ann Wise, Director  
Division of Administrative Law  
Health and Hospitals Section  
P. O. Box 44033  
Baton Rouge, LA 70804-4033  
(fax) (225) 342-1812