EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE INTERCEPT

WAIVER OF HEARING/APPEAL

Instructions

- Please print or type.
- Complete all applicable portions of this form.
- Submit the form by mailing the signed, dated and notarized original to the Executive Office of Health and Human Services, 3 West Road, Third Party Liability Unit, Virks Building 3rd Floor, Cranston, RI 02920 (401-462-2299).

Claim Information

Claimant's name_____

Date of injury_____ Claim number_____

Social Security Number_____

Address_____

City_____ State_____ Zip code_____

Insurer name_____

Address_____

City_____ State_____ ZIP code_____

Please read the information below before signing this form.

Rhode Island law permits parties to a claim to waive, in writing, their right to hearing/appeal.

To waive the thirty day (30) appeal period provided in R.I.G.L. Chapter 27-57.1 and rules and regulations of the Executive Office of Health and Human Services (EOHHS), the waiver must be filled in using this or a substantially similar form. Claimant and any non-attorney signature must be notarized.

The claimant and their attorney, if represented by an attorney, must sign the waiver. Non-attorneys may sign a waiver at the direction of the party they represent, but cannot sign at their independent discretion. When the required parties agree to waive their hearing/appeal rights, the EOHHS appeal period automatically expires.

This request for waiver of hearing/ appeal applies only to the claim and claim number specified herein, not to all past or future payments associated with another claim, if any. Therefore, waiving your right to hearing/appeal will not prohibit you from requesting a hearing to appeal other claims, if applicable.

The undersigned agree to waive the right to a hearing/appeal to EOHHS the determination and lien issued in the above claim and understand and agree that the amount of the lien shall be withheld from the amounts paid by_____ insurer and forwarded to the EOHHS as reimbursement for Medical Assistance the claimant received associated with the injury and loss relating to this claim.

The undersigned further understand and agree that they will be entitled any additional funds that may be due under this claim, if any, only after payment to the EOHHS.

The undersigned agree to waive the right to hearing/appeal effective on the date of signature below.

_____

Claimant Date

_____

Attorney Date

I am a non-attorney representative for the claimant herein named and I am signing at the direction of the claimant or as otherwise authorized by law (Evidence of any Guardianship, Power of Attorney, court order or to other recognized authority attached hereto)

_____

Non-Attorney Authorized Representative Date

STATE OF _____

COUNTY OF _____

On this _____day of _____, 20_____, before me the undersigned Notary Public, personally appeared _____ _____ personally known to me (or provided on the basis of satisfactory evidence) to be the person(s) whose name (s) are subscribed to the foregoing instrument and acknowledged to me they executed the same.

In WITNESS WHEREOF, I have set my hand and seal the day and year above written.

_____

Notary Public
Commission Expires: _____