REQUEST FOR ADMINISTRATIVE HEARING

Hospital Bill Complaint Program

Appeal of Penalty Assessed Pursuant to Health and Safety Code § 127436(c) and Title 22, California Code of Regulations Section 96051.32

Note: You have 30 calendar days from the date the administrative penalty was issued to file an appeal.

A. ADMINISTRATIVE PENALTY INFORMATION

Hospital Name: _____

Date of Administrative Penalty Notice: _____

B. REPRESENTATIVE INFORMATION

Representative Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

C. PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Email Address: _____

Authorized Representative Name, Address, Phone Number, and Email Address (if applicable):

_____

_____

D. APPEAL INFORMATION

This is an appeal of:

Penalty Number _____, Violation(s) _____

I have attached a copy of the Administrative Penalty Notice. _____ (Initial)

I have attached a statement of the basis for the appeal. _____ (Initial)

E. SIGNATURE

Print Name: _____ Title: _____

Signature: _____ Date: _____

Original/Digital Signature Required

****No later than five calendar days after filing the request for hearing, you must provide a copy of this Request for Administrative Hearing to the Hospital Bill Complaint Program by email at HFBP@hcai.ca.gov.**

Submit your completed form and supporting documents by mail or email to: Department of Health Care Access and Information, Office of Appeals and Hearings, 2020 West El Camino Avenue, Suite 1217 Sacramento, CA 95833. Email: HearingOfficer@hcai.ca.gov