REQUEST FOR WITHDRAWAL OF APPEAL

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH

The purpose of this form is for an appellant / beneficiary to withdraw his / her request for an appeal (either an Administrative Hearing or a Department Review).

APPELLANT INSTRUCTIONS:

- Answer ALL questions completely. •
- Please use a PEN and PRINT FIRMLY. •
- Remove the BOTTOM copy for your records. •
- If you have any questions, you may call toll free: •

1 (877) 833 - 0870.

After you complete this form, mail it in the enclosed postage • paid envelope to:

STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES FOR THE DEPARTMENT OF COMMUNITY HEALTH PO BOX 30763 LANSING MI 48909

Name		Telephone Number	Case Number
Vous Address (No. 9. Chroat Art No. etc.)			
Your Address (No. & Street, Apt. No., etc.)		Signature	Date Signed
City	State ZIP Code		
Docket Number.	Date of Scheduled Hearing	/ Review	Your Social Security Number
		,	,
Please CANCEL my request for an appeal for the following reason:			
The Department of Community Health has changed its action / decision.			
Other (Please explain):			
Authority: 42 CFR 431.200 – 431.250; 42 USC 1397aa; 42 USC 700 et seq.; MCLA 330.1001 et seq.; MCLA 400.1 et seq.;			
MCLA 333.1101 <u>et seq</u> .; Department of Community Health Appropriations Act. Completion: Is voluntary.			
The Department of Community Health is an equal opportunity employer, services, and programs provider.			
If you do not understand this, call the Department of Community Health. Si Ud. no entiende esto, llame a la oficina del Departamento de Salud Comunitaria.			
عة لو لاية ميتشيجن.	ة الصحة المحلية التاب	ذا لم تفهم هذا، اتصل بإدار	1 (877) 833 - 0870
DCH-0093 (SOAHR) (Rev.6/06)		COPY DISTRIBUTION: WHIT	E - Administrative Tribunal

DCH-0093 (SOAHR) (Rev.6/06)

WHILE Administrative Tribunal YELLOW - Person requesting a withdrawal