OSAH FORM 1

This form is available online at http://www.osah.ga.gov or by telephone request at (404) 657-2800

OSAH USE ONLY DOCKET NUMBER	AGENCY CODE	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE
	CMO	P_			

Date of hearing request: _____

County of provider's residence or place of business: _____

CMO Reference ID: _____

Reimbursement Amount: _____

Provider referrals: please select only one type of case:

☐ ER (Emergency Room) ☐ DEN (Denial) ☐ TERM (Termination) ☐ ELIG (Eligibility)

☐ In Network ☐ Out of Network

Provider Name: _____

Provider's Contact Person:

NAME:	TEL NO:	FAX NO:
PROVIDER ADDRESS INCLUDING ZIP CODE ON HEARING REQUEST	EMAIL:	

Provider's attorney:

NAME:	TEL NO:	FAX NO:
CURRENT ADDRESS INCLUDING ZIP CODE ON HEARING REQUEST	GEORGIA BAR NO:	EMAIL:

CMO: Care Management Organization

☐ Amerigroup Community Care ☐ Peach State Health Plan ☐ WellCare of Georgia

CMO's contact person:

NAME:	TEL NO:	FAX NO:
CURRENT ADDRESS INCLUDING ZIP CODE ON HEARING REQUEST	POSITION:	EMAIL:

CMO's attorney:

ATTORNEY NAME:	TEL NO:	FAX NO:
CURRENT ADDRESS INCLUDING ZIP CODE	GEORGIA BAR NO:	EMAIL: