

VIRGINIA MEDICAID/FAMIS APPEAL REQUEST FORM

(For Recipient Appeals Only)

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|---|---------------------|----------------------|
| First Name of Medicaid/SLH/FAMIS Applicant/Recipient: | Middle Name: | Last Name |
| Street or Post Office Box: | | |
| City and State: | Zip Code - 9-Digit: | Contact Telephone #: |
| Medicaid/SLH/FAMIS Case #: | Social Security #: | Other Telephone #: |

PLEASE SEND A COPY OF THE DENIAL LETTER OR NOTICE REGARDING THE ACTION YOU ARE APPEALING

() I am appealing the action of (agency name) _____

() I am a community spouse appealing the income/resource maintenance standard.

The date on the letter or date I was told about the Medicaid/FAMIS decision is: _____

The person who spoke with or wrote to me telling me about the action that I am appealing is:

Name: _____ Title: _____ Telephone Number: _____

The agency (check the appropriate space):

- () Placed/continued me in the Client Medical Management Program _____
() Denied me medical services or authorization for medical services _____
() Delayed my receipt of covered medical services. Name of service: _____
() Declared me not disabled by: (please check one) Medicaid Disability Unit () Social Security ()
() Changed, denied or proposed a change to my nursing home level of care _____
() Took other action which affected my receipt of Medicaid or medical services
() Failed to determine my eligibility within the time limit for: (please check one) () Medicaid () SLH () FAMIS
() Declared me ineligible or canceled my eligibility for _____

**** DO YOU NEED AN INTERPRETER? CIRCLE YES - OR - NO IF SO, WHAT LANGUAGE? _____**

Signature of Appellant: _____ Date: _____

This form must be signed by the client. If this form is being signed by anyone other than the Medicaid, SLH, or FAMIS client, please complete the next section and see the back of this form.

To be completed only if the client wishes to appoint someone to represent them during the appeals process

Name: _____

Address: _____

Area Code and Telephone number: _____

****IMPORTANT NOTICE****

The Department of Medical Assistance Services shall recover expenses paid on behalf of clients when Medicaid coverage is continued during the appeal process and the Hearing Officer upholds the agency's proposed action. Expenditures made for medical services from the original effective date of the proposed closure or reduction through the actual date of closure or reduction will be subject to recovery.

I am requesting a hearing because: _____

See other side for instructions.

INSTRUCTIONS

1. Complete this form as fully as possible or write a letter with the same information. **If you need more space for your comments, you may include additional sheets.**
2. Include names, addresses and telephone numbers. **PLEASE PRINT.**
3. The Medicaid/FAMIS applicant or recipient **MUST** sign the form. If the applicant or recipient cannot sign the form, explain why you are the appropriate representative. If you hold Power of Attorney (POA), include a copy of the POA document.
4. Mail or fax this form or letter with your notice from the agency to the address shown below.
 - The appeal form or letter must be *postmarked* within *thirty (30) days* of the agency's action.
 - The appeal form or letter must be *postmarked* within *thirty (30) days* of the date you were supposed to get a decision, but did not.
 - If neither of the above addresses your situation, mail in the appeal form or letter as soon as possible to protect your appeal rights.

SEND COMPLETED FORM OR APPEAL REQUEST LETTER TO:

Appeals Division
Virginia Dept. of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond Virginia 23219
Fax (804) 786-5778

IF YOU ARE NOT MAILING THE APPEAL FORM OR LETTER WITHIN 30 DAYS OF THE AGENCY'S ACTION, PLEASE ANSWER THE QUESTIONS BELOW:

1. Did you get a denial or cancellation notice? _____ What was the postmark date on the envelope? _____ When did you get the notice? _____
2. If you did not get a notice, how did you learn of the denial or cancellation?

3. Have you had any problems getting mail? _____ What kind of problems? _____
_____ Were problems reported to the post office? _____
4. Has your address changed? _____ When? _____ Did you tell the agency? _____
When? _____
5. Why didn't you file an appeal within 30 days of the agency action? _____

