VIRGINIA MEDICAID/FAMIS APPEAL REQUEST FORM

(For Client Appeals Only)

Last Name of Medicaid/FAMIS Applicant/Recipient:	First Name:	Middle Initial:	Suffix: (e.g., Sr., Jr., II, III)
Mailing Address (Street or Post Office Box)	City	State	Zip Code – 9-Digit
Date of Birth:	Gender: ( ) Male ( ) Female	Medicaid/FAMIS Case #:	Health Care #:
Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Primary Telephone #: (area code and number) _____ Alternate Telephone #: (area code and number)	Email Address: _____ Fax #: (area code and number)	

PLEASE SEND A COPY OF THE DENIAL/TERMINATION NOTICE REGARDING THE DECISION YOU ARE APPEALING.

I am appealing the decision of (agency name) _____

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

The name of the person who wrote to me or spoke to me about the decision I am appealing is:

Name: _____ Title: _____Telephone Number: _____

The agency (*check the appropriate space*):

( ) Denied my application or terminated my coverage for ( ) Medicaid or ( ) FAMIS.
( ) Refused to take my application for ( ) Medicaid or ( ) FAMIS.
( ) Failed to determine my eligibility within the time limit for ( ) Medicaid ( ) FAMIS
( ) Declared me not disabled.
( ) Requested repayment of benefits paid for medical services previously received.
( ) Denied or terminated waiver services. Name the waiver: _____ Service _____
( ) Denied medical services or authorization for medical services. Name of service: _____
( ) Transferred or discharged me from a nursing facility. Name of facility: _____
( ) Took other action that which affected my receipt of Medicaid, FAMIS or medical services.

Are you a community spouse appealing the income or resource determination for your spouse? ___Yes ___No

Write a brief statement about <u>why</u> you are requesting an appeal. _____

_____

_____

Preferred spoken language: _____*Preferred written language: _____
DO YOU NEED AN INTERPRETER? ( ) YES ( ) NO

****IMPORTANT NOTIFICATION****

The Department of Medical Assistance Services may recover expenses paid on behalf of clients when Medicaid or FAMIS coverage is continued during the appeal process and the hearing officer upholds the agency's action. Expenditures made for medical services (including MCO capitation fees) from the <u>original</u> effective date of the proposed closure or reduction through the <u>actual</u> date of closure or reduction will be subject to recovery.

***DO YOU WISH TO RECEIVE CONTINUED COVERAGE DURING THE APPEAL PROCESS IF YOU QUALIFY? __YES __ NO**

This section must be completed <u>only</u> if the client will be represented by another individual during the appeal process.

Representative's Name: _____Firm or Organization: _____

Address: _____

Area Code and Telephone number: _____

Signature of Client: _____ Date: _____

This form must be signed by the adult client, spouse, or parent (if the client is a minor child). If a representative who is not an attorney signs this form, the adult client must provide a signed statement or form authorizing that individual to act on his/her behalf during the appeal.

See other side for additional instructions.

INSTRUCTIONS (PLEASE PRINT)

1. **Complete this form as fully as possible or write a letter with the same information. If more space is needed, additional sheets may be included.**

2. **The ADULT Medicaid/FAMIS applicant or recipient (appellant), his/her spouse, or parent (if the applicant/recipient is a minor child) MUST sign this form. If a non-attorneyrepresentative is appointed, the representative's information must be shown on the front of this form, or the appellant must provide a signed statement giving the representative authority to appeal on his/her behalf.**

   - If the appellant is physically unable to sign a written statement, the person who signs this form must explain why he/she is the appropriate person to represent the appellant. The division shall allow a family member or other person acting on the appellant's behalf to be the representative.
   - If the appellant is mentally unable to sign a written statement, the division shall require written documentation that a family member or other person has been appointed or designated as his legal representative.

3. **The time limit for filing an appeal is shown below:**

   - The appeal form or letter must be *postmarked* within *thirty (30) days* of receipt of notice of the agency's decision or the date the applicant/recipient was supposed to get a decision, but did not.
   - If neither of the above circumstances apply, send the Appeal Request Form or appeal letter as soon as possible to protect the individual's appeal rights.

SEND THE COMPLETED FORM OR APPEAL REQUEST LETTER AND RELATED DOCUMENTS TO THE:

Appeals Division
Dept. of Medical Assistance Services
600 East Broad Street
Richmond Virginia 23219
Fax (804) 612-0036

IF MORE THAN 30 DAYS HAVE PASSED SINCE YOU RECEIVED NOTICE OF THE AGENCY'S DECISION, OR SINCE THE DATE THE AGENCY SHOULD HAVE MADE A DECISION, PLEASE ANSWER THE QUESTIONS BELOW:

1. **Did you get a denial or termination notice? ___ Yes ___ No 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 termination? _____**
   _____
   _____

3. **Have you had any problems getting mail? ___ Yes ___ No What kind of problems?_____**
   _____
   Were problems reported to the post office? ___ Yes ___ No

4. **Has your address changed? ___ Yes ___ No If so, when? _____**

5. **If your address changed, did you tell the agency? ___ Yes ___ No If yes, what date did you tell the agency that your address changed? _____**

6. **Why didn't you file an appeal within 30 days of the date you received notice of the notice of agency's decision, or within 30 days of learning of the agency's decision? _____**
   _____
   _____