

VIRGINIA MEDICAID/FAMIS APPEAL REQUEST FORM

(For Client Appeals Only)

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|--|---|-------------------------------|-----------------------------------|
| 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) | Email Address: | |
| | Alternate Telephone #: (area code and number) | Fax #: (area code and number) | |

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

I am appealing the action 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 me 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 why you are requesting an appeal. _____

Preferred spoken language: _____ *Preferred written language: _____

DO YOU NEED AN INTERPRETER? YES NO

How do you prefer to be contacted about your appeal request?

Email (provided above) Fax (provided above) Regular postal mail at the mailing address provided.

If you choose to get information by any method other than mail, do you also want to get paper copies in the mail? Yes No

****IMPORTANT NOTIFICATION****

The Department of Medical Assistance Services shall 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 original effective date of the proposed closure or reduction through the actual 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 only 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. 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 **MUST** sign the form. If the adult applicant or recipient cannot sign the form, the individual who signs the form must explain why he/she is the appropriate person to represent the applicant/recipient. If the representative holds Power of Attorney (POA), a copy of the POA document must be provided. A signed statement from the adult applicant/recipient is acceptable.
3. Mail or fax this form or an appeal letter along with the 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 decision or the date the applicant/recipient was supposed to get a decision, but did not.
 - If neither of the above applies, mail in 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
Virginia Dept. of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond Virginia 23219
Fax (804) 612-0036

IF MORE THAN 30 DAYS HAVE PASSED SINCE THE AGENCY'S ACTION, OR SINCE THE DATE THE AGENCY SHOULD HAVE TAKEN ACTION, 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 cancellation? _____

3. Have you had any problems getting mail? _____ 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 of the agency decision? _____

