VIRGINIA MEDICAID / FAMIS CLIENT APPEAL REQUEST FORM

A fillable form is available at www.dmas.virginia.gov

Fill out this form completely including why you are appealing or write a letter with the same information. Include a copy of the written notice you are appealing.

Signing guidelines:

If the appeal request is for **someone who is physically or mentally unable** to sign a document, clearly explain to us why he or she is physically or mentally unable to sign. Also let us know, to the best of your knowledge, if there is any known guardian.

If the appeal request is for **someone who has died**, provide written proof that you can represent them. If you do not have written proof, clearly explain your relationship to the deceased and why you are appealing for him or her. Also let us know, to the best of your knowledge, if there is any known executor or administrator of the estate.

A parent or legal guardian must file appeal requests for a **minor child**. If filing an appeal as a child's legal guardian, include proof of guardianship.

In some cases, we may require a power of attorney, a written statement from the appellant, or other additional information.

Time limit for filing an appeal:

The time limit for filing an appeal is on the written notice from the agency. In most cases it is 30 days.

If you are filing your appeal late, the DMAS Appeals Division may grant an extension of the time limit if the reason is due to a good cause (as defined by regulation). There is a Good Cause Questionnaire on page 4 where you can provide information about why you filed your appeal late. A DMAS Hearing Officer will evaluate your response and make a determination whether filing your appeal late was due to a good cause.

Note: Managed Care Organization (MCO) appeals have two major differences 1) you must first appeal to the MCO and 2) you have 120 days to file an appeal with DMAS once you receive a final decision from the MCO with no exception.

Ways to ask for an appeal:

- **By email.** Email your appeal request to DMAS at **appeals@dmas.virginia.gov**
- **By fax.** Fax your appeal request to DMAS at **(804) 452-5454**
- **By mail or in person.** Send or bring your appeal request to **Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219**
- **By phone.** Call DMAS **at (804) 371-8488 (TTY: 1-800-828-1120)**

VIRGINIA MEDICAID / FAMIS CLIENT APPEAL REQUEST FORM

A fillable form is available at www.dmas.virginia.gov

Last Name of Medicaid/FAMIS Appellant	First Name	Middle Initial	Suffix (Sr., Jr., II, III)

Mailing Address - Street or PO Box	Apt.#	City	State and Zip	Date of Birth

Medicaid / FAMIS Case #	Client ID #	Gender	Primary Phone # with Area Code
		☐ Male ☐ Female	

Preferred Spoken Language	Preferred Written Language	Do you need an interpreter?	Alternate Phone # with Area Code
		☐ Yes ☐ No	

Social Security #	Email	Have you already filed an appeal for the same issue (e.g. faxed and mailed)? ☐ Yes ☐ No

Are you a community spouse appealing the income or resource determination for your spouse? ☐ **Yes** ☐ **No**

Did you receive a written notice from an agency? ☐ **Yes** ☐ **No**

Agency Name _____ **Telephone** _____

Notice Dated _____ **Case Worker** _____

Include a copy of the written notice you are appealing.

Managed Care Organization (MCO)

Are you appealing a decision by an MCO?

☐ Yes ☐ No

If yes, you must first appeal to the MCO. If you disagree with the MCO's final decision, you can appeal that decision to DMAS.

The agency (check all that apply):

- ☐ Denied my application or terminated my coverage for: ☐ Medicaid ☐ FAMIS
- ☐ Refused to take my application for: ☐ Medicaid ☐ FAMIS
- ☐ Failed to determine my eligibility w ithin the time limit for: ☐ Medicaid ☐ FAMIS
- ☐ Requested repayment of benefits paid for medical services previously received.
- ☐ Declared me not disabled.
- ☐ Took other action w hich affected my receipt of Medicaid, FAMIS or other medical services.
- ☐ Denied medical services or authorization for medical services. Name of service: _____
- ☐ Denied or terminated w aiver services. Waiver name and service: _____ _____
- ☐ Transfered or discharged from a nursing facility. Facility name and phone #: _____ _____

Write a brief statement about why you are requesting an appeal. Attach an additional page if you need more space.

Important Information if Requesting Continued Coverage	**Continued Coverage**
If the final appeal decision supports the agency's action, you may be expected to repay DMAS for all services received during the appeal process. For this reason, you may choose not to receive continued coverage.	If you had Medicaid coverage before your benefits were canceled, do you want continued coverage through the appeal process if you qualify? ☐ Yes ☐ No

Authorized Representative

Will the appellant be represented by another individual during the appeal process? If yes, fill out and return the Authorized Representative Form on page 3 of this Appeal Request. ☐ Yes ☐ No

Signature of Appellant* _____ **Date** _____

*See signing guidelines on Page 1.

VIRGINIA MEDICAID / FAMIS APPEAL
AUTHORIZED REPRESENTATIVE FORM

Appellant Information

Name: _____ Date of Birth: _____ Social Security #:_____

Medicaid / FAMIS Case #:_____ Phone with Area Code: (_____)_____

I understand:

- I can represent myself
- This authorization is voluntary and I have the right to refuse to sign or cancel it at any time
- This authorization will expire automatically when my Medical Assistance appeal is closed
- My signature does not waive my financial obligation if the appeal is decided in the agency's favor
- My authorized representative has access to all protected health information regarding my appeal and I agree that this information may be disclosed to other persons in connection with this appeal

Authorized Representative Information

I appoint _____ as my representative during my Medical Assistance appeal.

Authorized Representative's Relationship to the Appellant: _____

Authorized Representative's Address: _____

Authorized Representative's Phone with Area Code: (_____)_____

Signature of Appellant / Parent or Guardian of Minor Child: _____ Date: _____

If signing on behalf of the appellant, see section below.

If the Appellant is deceased, the Authorized Representative may sign below:
I certify that (Appellant) _____ is deceased. To the best of my knowledge, the appellant does not have an executor or administrator of their estate. Initial _____

If the Appellant is physically or mentally unable to sign, the Authorized Representative may sign below:
I certify that (Appellant) _____ is physically or mentally unable to sign this Authorized Representative Form. To the best of my knowledge, the appellant does not have a legal guardian. Initial _____
Describe the physical or mental inability: _____
_____

Signature of Authorized Representative: _____ Date: _____

DMAS Appeals Division			
Email	**Fax**	**Phone**	**Mail**
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219

VIRGINIA MEDICAID / FAMIS APPEAL
GOOD CAUSE QUESTIONNAIRE

Fill out this form if you are filing an appeal request more than 30 days after receipt of the agency's written notice.

Appellant Information

Name: _____ Date of Birth: _____ Social Security #:_____

Medicaid / FAMIS Case #:_____ Phone with Area Code: (_____)_____

1. Did you receive a written notice from the agency? ☐ Yes ☐ No
2. What date did you receive the written notice? _____
3. If you did not receive a written notice, how did you find out about the denial or termination?
   _____
   _____
4. What date did you find out about the denial or termination of coverage? _____
5. Have you had problems receiving mail? ☐ Yes ☐ No If yes, explain: _____
   _____
6. Has your address changed? ☐ Yes ☐ No Date of change: _____
7. Did you tell the agency about your address change? ☐ Yes ☐ No Date notified: _____
8. Why are you appealing now? _____
   _____
9. Did you contact the agency regarding the denial or termination? ☐ Yes ☐ No Date contacted: _____
10. Were you prevented from filing an appeal? ☐ Yes ☐ No How were you prevented:_____
    _____
11. Did you file an appeal with another agency or with your managed care organization (MCO) regarding the denial or termination? ☐ Yes ☐ No Date appeal was filed: _____
12. Enter the name of the agency you filed an appeal with: _____

_____ _____
Printed Name Date

_____
Signature

DMAS Appeals Division			
Email	**Fax**	**Phone**	**Mail**
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