VIRGINIA MEDICAID/FAMIS CLIENT APPEAL REQUEST FORM

Online fillable form available at www.dmas.virginia.gov

Complete this Appeal Request Form as fully as possible or write a letter with the same information. Please clearly explain why you are appealing. If more space is needed, additional sheets may be included. For your convenience, the form can be completed online and mailed or faxed to the Appeals Division.

For a deceased appellant, you must submit evidence from a court that you qualified as the Executor or the Administrator of the appellant's Estate. A Power of Attorney or Last Will and Testament is not acceptable proof of representation for a deceased appellant.

Signing Guidelines:

- If the appeal is **for a minor child**, the parent must sign this form. If the parent wishes to appoint a representative, include the Authorized Representative Form on page 3 of this Appeal Request. If you are appealing as a child's legal guardian, proof of guardianship is needed.
- In cases where a **spouse or family member** is representing the adult appellant, include the Authorized Representative Form on page 3 of this Appeal Request. The adult appellant must sign the form or include a Power of Attorney authorizing that person to act on their behalf during the appeal.
- If the appellant is **physically unable** to sign the Authorized Representative Form, the person acting on their behalf must fill out the Authorized Representative Form on page 3 of this Appeal Request, and describe the physical reason why the appellant cannot sign the form.
- If the appellant is **mentally unable** to sign the Authorized Representative Form, the person acting on their behalf must submit legal proof of guardianship with the appeal.

Time Limit for Filing an Appeal:

The appeal must be **postmarked or faxed** within **thirty (30) days** of receiving the agency's decision or the date the applicant was supposed to get a decision, but did not.

Send the Appeal Request Form or an appeal letter as soon as possible to protect appeal rights.

Send the completed Appeal Request Form or appeal request letter and related documents including the Denial/Termination Notice regarding the decision to:

Appeals Division
Dept. of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

or

Fax (804) 452-5454

Are you filing this appeal within 30 days of receipt of the agency's decision or by the date the agency should have made a decision? If no, answer the Good Cause Questionnaire below. ☐ Yes ☐ No

Good Cause Questionnaire

1. **Did you get a denial or termination notice?** ☐ Yes ☐ No
2. **What was the postmark date on the envelope?** **When did you receive the notice?**
3. **If you did not receive a notice, how did you learn of the denial or termination?**
4. **Have you had any problems getting mail?** ☐ Yes ☐ No **What kind of problems?**
   Were problems reported to the post office? ☐ Yes ☐ No
5. **Has your address changed?** ☐ Yes ☐ No **If so, when?**
6. **If your address changed, did you notify the agency?** ☐ Yes ☐ No **If yes, what date did you tell the agency that your address changed?**
7. **Why didn't you file an appeal within 30 days of the date you received notice of the decision, or within 30 days of learning of the agency's decision?**

VIRGINIA MEDICAID/FAMIS CLIENT APPEAL REQUEST FORM

Last Name of Medicaid/FAMIS Appellant:		First Name:	Middle Initial:	Suffix: (Sr., Jr., II, III)
Mailing Address - Street or PO Box		City State	Zip	Date of Birth
Medicaid/FAMIS Case #	Client ID #	Gender ☐ Male ☐ Female	Primary Telephone # with area code	
Preferred spoken language	Preferred written language	Do you need an interpreter? ☐ Yes ☐ No	Alternate Telephone # with area code	
Social Security Number		Have you already filed an appeal for the same issue (e.g. faxed and mailed) ☐ Yes ☐ No Date	Email	

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

Did you receive a denial or termination notice from an Agency? ☐ **Yes** ☐ **No**

Agency Name **Telephone**

Notice Dated **Case Worker**

Include a copy of the Denial / Termination Notice regarding the decision you are appealing.

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 within the time limit for: ☐ Medicaid ☐ FAMIS

☐ Requested repayment of benefits paid for medical services previously received.

☐ Declared me not disabled.

☐ Denied medical services or authorization for medical services. Name of service:

☐ Denied or terminated waiver services. Name the waiver and service:

☐ Transferred or discharged from a nursing facility. Name the facility:

☐ Took other action which affected my receipt of Medicaid, FAMIS or other medical services.

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

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. Payments made for medical services (including MCO fees) from the original proposed date of termination or reduction in services, through the actual date of termination or reduction will be subject to recovery.

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? Yes No

If yes, fill out and return the Authorized Representative Form on page 3 of this Appeal Request or submit a Power of Attorney. For a deceased appellant, submit evidence from a court that you qualified as the Executor or Administrator of the appellant's Estate. A Power of Attorney, Last Will and Testament, or the Authorized Representative Form is not acceptable proof of representation for a deceased appellant.

Signature of Appellant **Date**

This form must be signed by the adult appellant or a parent of the minor child named at the top of this form. If the authorized representative who is not an attorney signs this form, fill out and return the Authorized Representative Form on page 3 of this Appeal Request.

For an online fillable form go to www.dmas.virginia.gov

VIRGINIA MEDICAID / FAMIS CLIENT APPEAL
AUTHORIZED REPRESENTATIVE FORM

Appellant Information

Last Name: ______________________ First Name: _____________________ Date of birth: _______________

Social Security Number: _________________________________ Case number: _______________________

Telephone number with area code: ____

Authorized Representative Information

I hereby appoint ____ as my Authorized Representative to act on my behalf during my Medicaid / FAMIS appeal. This authorization will expire automatically upon the completion of my appeal to DMAS or if I revoke it in writing to:

Appeals Division
Dept. of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

or

Fax (804) 452-5454

My relationship to the Authorized Representative: ____

My Authorized Representative's address: ____

My Authorized Representative's telephone number with area code: ______________________________________

- This authorization is at my request and I understand that I have the right to refuse to sign this authorization and that it is strictly voluntary
- I understand that my signature does not waive my right to represent myself
- I understand that my signature does not waive my financial obligation should the appeal be decided in the agency's favor
- I authorize my Authorized Representative to have access to all protected health information regarding my appeal and agree that this information may be disclosed to other persons in connection with this appeal

Printed Name of Appellant / Parent of Minor Child: ____

Signature of Appellant / Parent of Minor Child: _________________________________ Date: ________________

If appellant is physically unable to sign, the Authorized Representative may sign below:

I hereby certify that (appellant) ____ is physically unable to sign this Authorized Representative Form. Describe the physical incapacity affecting the appellant.

____
____
____
____
____

Signature of Authorized Representative: _____________________________________ Date: ________________

NOTE: This form is not valid for appellants who are mentally unable to sign or deceased. If the appellant is mentally unable to sign, the person acting on their behalf must submit legal proof of guardianship with the appeal. If the appellant is deceased, you must submit evidence from a court that you qualified as the Executor or the Administrator of the appellant's Estate. A Power of Attorney or Last Will and Testament is not acceptable proof of representation.