VIRGINIA MEDICAID/FAMIS APPEAL REQUEST FORM
INSTRUCTIONS (PLEASE PRINT)

1. Complete this 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, you can complete this form online, print, sign and mail or fax to the address or fax number below.

2. Send this form, and a copy of the Denial/Termination Notice regarding the decision you are appealing.

3. **Signing Guidelines:**

   - If the appeal is **for a minor child**, the parent must sign this form. If the parent wishes to appoint a representative, the representative's information must be entered on the Appeal Request Form in the "Representative's Name" field. If the child has a legal guardian, proof of guardianship is needed.
   - In cases where a **spouse or family member** is representing the adult appellant, the spouse or family member's information must be entered on the Appeal Request Form in the "Representative's Name" field. The adult appellant must sign the form or include a signed statement authorizing that individual to act on their behalf during the appeal.
   - If the appellant is **physically unable** to sign a written statement, the person who signs this form must certify and explain why they are the appropriate person to represent the appellant. A family member or other person may act on the appellant's behalf as their representative.
   - If the appellant is **mentally incapable** of designating a representative, the Appeals Division requires legal proof that a family member or other person has been appointed or designated as their legal representative.

4. **The 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.

If none 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 Appeal Request Form or appeal request letter and related documents including the Denial/Termination Notice regarding the decision to the:

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

OR

By 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 APPEAL REQUEST FORM

(For Client Appeals Only)

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

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

Medicaid/FAMIS Case #	Client ID #	Gender	Primary Telephone # with area code
		☐ Male ☐ Female	

Preferred spoken language	Preferred written language	Do you need an interpreter?	Alternate Telephone # with area code
		☐ Yes ☐ No	

Social Security # (MUST INCLUDE IF ASSIGNED)	Have you already filed an appeal for the same issue (e.g. faxed and mailed)	Email Address
	☐ Yes ☐ No Date	

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.

If you received Medicaid coverage prior to the cancellation or termination of benefits, do you wish to receive Continued Coverage during the appeal process if you qualify?

☐ Yes ☐ No

Authorized Representative (only if the appellant will be represented by another individual during the appeal process)

Representative's Name Firm, Organization, Relationship

Area Code and Phone Address

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 an authorized representative, who is not an attorney, signs this form for the appellant, the appellant must provide a signed statement authorizing that individual to act of their behalf or on behalf of their minor child during the appeal.

Please reference the Instructions Page for additional signing information.

For an online fillable form go to WWW.DMAS.Virginia.gov

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