VIRGINIA MEDICAID / FAMIS CLIENT APPEAL REQUEST FORM

To file your appeal online via the Appeals Information Management System (AIMS) portal visit https://www.dmas.virginia.gov/appeals

To file via email, fax, or mail, 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 on their behalf. 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.

Organizations need to have written documentation from the appellant authorizing them to appeal on their behalf. If the appellant is deceased, provide authorization by an administrator or executor of the estate.

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: For Managed Care Organization (MCO) appeals there are three major differences:

1) You have to first appeal to the MCO
2) You have 120 days to file an appeal with DMAS once you have received a final decision from the MCO
3) By regulation, there is no good cause for filing a late appeal

Ways to ask for an appeal:

1) **Electronically.** Online at **https://www.dmas.virginia.gov/appeals** or email to **appeals@dmas.virginia.gov**
2) **By fax.** Fax your appeal request to DMAS at **(804) 452-5454**
3) **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
4) **By phone.** Call DMAS at **(804) 371-8488 (TTY: 1-800-828-1120)**

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IMPORTANT: Please attach all documents that you would like the Appeals Division to consider. Any supporting documents you submit with your appeal request will be considered in rendering a decision.

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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 Member ID #	Client ID #	Primary Phone # with Area Code	Alternate Phone # with Area Code

Preferred Spoken Language	Preferred Written Language	Do you need an interpreter? Yes No	Email

Do you need a reasonable ADA accommodation? Explain	What way would you like us to communicate with you? Email Mail	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 within the time limit for:	Medicaid	FAMIS

Requested repayment of benefits paid for medical services previously received.

Declared me not disabled.

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

Denied medical services or authorization for medical services. Name the service:

Denied or terminated waiver services. Waiver name and service:

Transferred or discharged from a nursing facility. Facility name and phone #:

Important: Attach any documents you believe support your position in the appeal

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

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.

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 or an organization 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

You can use this form to appoint an individual or organization to act as your authorized representative.
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

Appellant Information (tell us about you)

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

Medicaid Member ID #:_____ Phone: (_____)_____

Authorized Representative Information (tell us about who you would like to represent you)

Authorized Rep Name or Organization _____ Phone Number (_____)_____

Authorized Representative's Relationship to the Appellant: _____

Preferred written language (letters will be sent in this language) English Spanish

Authorized Representative's Address: _____

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

For Organizations: The appellant must give written authorization to act on their behalf. For deceased appellants, provide documentation from the executor or administrator of the estate naming you as the Authorized Representative, this is needed to file an appeal.

If you are filing an appeal on behalf of an appellant who is unable to sign

To the best of my knowledge does the appellant have a legal guardian? Yes No

If the appellant is physically or mentally unable to sign tell us why _____

_____

Is the appellant deceased? ____ Yes ____ No Your relationship the deceased_____
To the best of my knowledge, the appellant does not have executor or administrator of their estate. Initial _____

Signature of Authorized Representative: _____ Date: _____

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

Print

VIRGINIA MEDICAID / FAMIS APPEAL
GOOD CAUSE QUESTIONNAIRE FOR NON MCO APPEALS

Only required for late appeals. Complete this form if you are filing an appeal request more than 30 days after receipt of the agency's written notice. By regulation, there is no good cause for late MCO appeals which have a longer deadline to file of 120 days.

Appellant Information

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

Medicaid Member ID #: _____ 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				
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