Insert Logo Here

Address
City, State, Zip
Telephone
(TTY)

Appeal for Reconsideration of Denial

Instructions for Participant: Please complete this form to request an appeal of our decision to deny, defer, or modify a service or payment of a service that you or your representative requested. Send the completed form to the address below. An impartial third party not involved in the initial decision-making process will review your appeal. Please note that DHCS treats all participant information included in the appeal process as confidential.

Date: _____

To: **[Quality Assurance Department or designee]**
[PACE Program]
[Address]
[City, State, Zip]

From: _____
Name of Participant / Participant Representative/ Provider [Please print name]

_____
Address & Telephone No. of the Person identified on the above line

On Behalf of: _____
Print Participant's Name [if other than participant filing]

As a **participant / representative / provider** (circle one) of **[PACE Program]**, I hereby appeal the denial, deferral, or modification of the following service(s) or payment for service:

_____

_____

I wish to appeal the denial, deferral, or modification of the above service(s) or payment for service(s) for the reasons indicated below: (*for example*, *explain why you should receive the service and how it would benefit you or why we should pay for the service).*

_____

_____

If I continue to receive the disputed service until the appeals process is completed, I fully understand that I may be financially responsible for payment of the disputed service if the decision to NOT cover or reduce services is upheld or not made in my favor.

I am requesting that **[PACE Program]** continue to provide me with the disputed service during the appeal process: (please check box) Yes___ No___

Please note: Additional pages may be attached if more space is needed

Internal Staff Use Only:

Receipt and Acknowledgement of Appeal:

- ❑ Appeal for Reconsideration of Denial Letter received by the **[QA Department]**: Date_____
- ❑ **[PACE Staff]** Receipt of Appeal for Reconsideration of Denial Letter documented into Appeal Log (day received): Date: _____
- ❑ **[Medical Director]** notified of the appeal concerning disputed health care services or urgent appeal: Date**:**_____
- ❑ **[Manager/Supervisor]** notified of the appeal concerning coverage decisions or payment decisions. Date**:**_____
- ❑ **[QA Staff]** sent a written acknowledgment of *standard* appeal to participant (within 5 days): Date Sent:_____

Thirty calendar days (or more quickly if participant's health condition requires) from the day the appeal was received, either:

- ❑ The decision to *reverse* the denial, deferral, modification or refusal to pay for services is made.
    - The **[Medical Director]** or **[QA staff]** provides written response to *standard* appeal within 30 calendar days (or sooner if health condition requires). Notice of Appeal Resolution, Attachment 5. Date Sent: _____.
- ❑ The decision to *uphold* the denial, deferral, modification or refusal to pay for services is made.
    - The **[Medical Director]** or **[QA staff]** provides written response to standard appeal within 30 calendar days (or sooner if health condition requires) to participant and his/her representative, HPMS, and DHCS-LTCD. Notice of Appeal Decision, Attachment 6. Date Sent: _____
    - The **[Medical Director]** or **[QA staff]** provides written information to participant and/or his/her representative on external review options for appeal.

Expedited Review: If the appeal involves an imminent and serious threat to the health of the participant

- ❑ **[QA Staff]** informs participant by telephone or in person of receipt of ***expedited*** appeal (within one (1) business day) of receipt of the expedited appeal): Date:_____ Time:_____
- ❑ The **[Medical Director]** or **[QA staff]** provides written response to reverse decision on expedited appeal within 72 hours of receipt of appeal. Notice of Appeal Resolution, Attachment 5. Date Sent: _____. OR
- ❑ The **[Medical Director]** or **[QA staff]** provides written response to uphold decision on expedited appeal within 72 calendar days to participant and his/her representative, HPMS, and DHCS-LTCD. Notice of Appeal Decision, Attachment 6. Date Sent: _____
    - The **[Medical Director]** or **[QA staff]** provides written information to participant and/or his/her representative on external review options for appeal.

Comments: