

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.

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: _____
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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.
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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: