

# STATE HEALTH BENEFITS PROGRAMS APPEAL FORM

Persons enrolled in Key Advantage or Cost Alliance may use this form to appeal to the Director of the Department of Human Resource Management (DHRM) regarding a denied claim. **To be considered a valid appeal, the Director must receive it within 60 days of the final adverse decision of the plan.** Also, this form may be used to appeal directly to the Director of DHRM on matters of eligibility, regardless of the State plan in which the appellant is enrolled.

Your Name \_\_\_\_\_ Member I.D. # \_\_\_\_\_  
Name of Enrolled Employee \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date of Service \_\_\_\_\_  
Name of Physician, Hospital, or  
Other Health Care Provider \_\_\_\_\_

**CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR THE APPEAL:**

- Disagree with the amount paid on a claim or with the amount of member copayment
- Believe the claim was for a covered service and should not be denied for payment
- Believe a service was medically necessary, though denied as not medically necessary
- Eligibility issue. Please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Other. Please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ATTACH DOCUMENTS RELEVANT TO YOUR APPEAL.** For example: Explanations of Claims Processed, other correspondence from plan, letter from your physician, bill from your health care provider. Are documents attached?  Yes  No

**APPEALS TO THE DIRECTOR OF THE DEPARTMENT OF HUMAN RESOURCE MANAGEMENT** should be addressed as follows:

Director, Department of Human Resource Management  
101 North 14<sup>th</sup> Street  
Richmond, Virginia 23219

Please mark the envelope Confidential – Appeal Enclosed

What specific remedy do you seek in filing this appeal? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_