

PATIENT APPEAL PROCESS

You have the right to appeal. You can appeal the decision of ineligibility if you believe there are reasons you should qualify for financial assistance that were not addressed in the interview with the Patient Services Representative (PSR).

If, at the end of your interview, the PSR has determined that you are not eligible for financial assistance, the PSR will explain to you why you have been determined ineligible.

If you believe you have extenuating circumstances, please complete the attached letter along with any additional information and mail to the Appeals Supervisor within 90 days from the date you were found ineligible and the supervisor will present it to the Appeal Committee. Be sure to include any special circumstances in your life that have made it difficult for you to be able to afford medical care. You can either mail or e-mail this appeal to:

Representative _____

Albuquerque, NM 87xxx

OR e-mail to _____

All appeal letters are reviewed by the Appeal Committee. The Appeal Committee will consider your medical bills, medical history, the hospital policy, the reason for the denial, and then re-evaluate your eligibility. You will be informed of whether your appeal has been approved or not within 30 days after UNM Hospitals has received the appeal letter.

If your appeal is denied, you will receive a letter of denial with an explanation. This second letter of denial will give you the option of appealing to the Executive Appeals Committee by writing to:

Executive Appeals Committee

1131 University N.E. Suite D

Albuquerque, NM 87102

The denials will be re-evaluated by the Executive Appeals Committee, who will consider medical bills, medical history, UNMH policy, your current and future financial medical and financial situation.

You will receive a written response to this Executive Appeal letting you know if your appeal is approved or if the original determination of ineligibility has been upheld.

Please be aware that you will still be responsible for any bills while your case is under review. You may contact 272-2521 to set up payment arrangements.

Appeal Letter

Please check one: 1st letter of appeal or 2nd letter of appeal.

Please use the template below for your appeal request and be as detailed as possible. Feel free to attach additional sheets of paper if you need more space. Please complete this form in the language you are most comfortable with.

Today's Date:

From (Patient's Name):

Date of Birth:

Medical Record Number:

Date you received Letter of Ineligibility:

Please give a listing of:

What conditions you being treated for:

Medications currently taking:

How often you see a doctor:

Monthly expenses for your medical care:

Please explain any financial hardships that are affecting your ability to pay for medical bills or medications: _____

Please give a brief description of your current needs for medical care: _____

Print Name

Exhibit G

Signature

Date

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