PATIENT APPEAL PROCESS & APPEAL REQUEST FORM

for UNM Care and Out-of-County Care Programs

You have the right to appeal the denial of your UNM Care or Out-of-County Care application. If you were denied, but you believe there are reasons you should qualify for UNM Care or Out-of-County Care, you can ask for your application to be reconsidered (or appeal the decision). You must send your appeal letter within 45 days from the date you were found ineligible.

At the end of your appointment or after you have submitted all of the required documents, the Financial Assistance team will notify you if you are approved or denied UNM Care or Out-of-County Care. If we determine that you are denied, you will get a letter that explains the reason for the denial.

You can appeal if you disagree with the reason for the denial. Some examples include:

- You feel your condition will result in significant bills in the upcoming year that you can not afford, OR
- You believe your treatment or procedure is medically necessary, OR
- There is a good reason that you should get benefits that you think we did not consider.

Instructions and Process for Appeal 1

Please complete the attached Appeal Request Form and gather any additional information or documents you want to be considered in your appeal. 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 must send your appeal within 45 days from the date your application was denied. You can either mail or email your appeal request form and any additional documents to:

Representative _____

_____

Albuquerque, NM 87xxx

OR email to FinancialAssistance@salud.unm.edu or to your representative_____

All appeal letters are reviewed by the Appeal Committee. The Appeal Committee will consider your appeal request form and any additional documents you sent, your medical bills, your medical history, UNMH 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.

Instructions and Process for Appeal 2

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. You can request this appeal by calling the Patient Financial Assistance Representative you met with during your appointment at 505-272-2521 and telling them you would like your denial to be re-evaluated by the Executive Appeals Committee. You do not need to send any other forms or documentation, but if there is additional information you would like to be considered, send it 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 your Appeal Request Form and any additional information and documents you sent, your medical bills, your medical history, UNMH policy, the reason for your denial, and 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 denial has been upheld.

Please be aware that you will still be responsible for any bills while your case is under review. You may contact 505-272-2521 to set up payment arrangements.

The Appeal Request Form is on the next page.

Appeal Request Form

To request an appeal, please complete the form below or answer the questions on a separate piece of paper. Include as much detail 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:

Patient's Name:

Date of Birth:

Medical Record Number:

Date on your UNM Care or Out-of-County Care denial letter:

What conditions are you being treated for?

What medications are you currently taking?

How often do you see a doctor?

What are your 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:

Please include any other information that will help us in reconsidering your denied application:

Print Name

Signature Date

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