VIRGINIA MEDICAID / FAMIS APPEAL
GOOD CAUSE QUESTIONNAIRE FOR NON MCO APPEALS

Only required for late appeals. Complete this form if you are filing an appeal request more than 30 days after receipt of the agency's written notice. By regulation, there is no good cause for late MCO appeals which have a longer deadline to file of 120 days.

Appellant Information

Name: _____ Date of Birth: _____ Social Security #:_____

Medicaid Member ID #: _____ Phone with Area Code: (____)_____

1. Did you receive a written notice from the Agency? ☐ Yes ☐ No
2. What date did you receive the written notice? _____
3. If you did not receive a written notice, how did you find out about the denial or termination?
   _____
4. What date did you find out about the denial or termination of coverage? _____
5. Have you had problems receiving mail? ☐ Yes ☐ No If yes, explain: _____
   _____
6. Has your address changed? ☐ Yes ☐ No Date of change: _____
7. Did you tell the agency about your address change? ☐ Yes ☐ No Date notified: _____
8. Why are you appealing now? _____
9. Did you contact the agency regarding the denial or termination? ☐ Yes ☐ No Date contacted: _____
10. Were you prevented from filing an appeal? ☐ Yes ☐ No How were you prevented:_____
    _____
11. Did you file an appeal with another agency or with your managed care organization (MCO) regarding the denial or termination? ☐ Yes ☐ No Date appeal was filed: _____
12. Enter the name of the agency you filed an appeal with: _____

_____ _____
Printed Name Date

_____
Signature

DMAS Appeals Division				
Email	**Fax**	**Phone**	**Mail**	**Portal**
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219	AIMS Portal: https://www.dmas.virginia.gov/appeals