Georgia Department of Public Health

CHILDREN'S MEDICAL SERVICES (CMS)
PATIENT AND FAMILY APPEALS REQUEST FORM

I _____ am appealing a decision of the CMS Program.

Patient/ Legal Representative (Relationship to Patient)

CMS Patient/Applicant Information

First Name:	Middle Name:	Last Name:	Patient CMS ID No. (if applicable):
Mailing Address:			

City:	State:	Zip Code:	County:	Contact Number:

I was notified of the decision from CMS on: _____ by _____
Date CMS Care Coordinator

Children's Medical Services (*check the appropriate space*):

□ Declared patient/applicant ineligible or the CMS program.

□ Denied patient/applicant authorization for medical services.

□ Other action taken which affected patient's/applicant's receipt of CMS services:
Name of Service: _____

I would like to provide the following information and suggestions to resolve the issue:

_____

_____

	Representative Name:
	Address:
_____ Patient/Legal Representative Signature Date	Telephone:

Appeal Request Form Instructions

The Children's Medical Services (CMS) program offers you the opportunity to appeal decisions regarding program eligibility and services. There are two areas in which you may file an appeal:

- CMS determines you are not eligible for CMS
- A service request is denied by CMS

1. Complete this form as fully as possible or write a letter with the same information.
2. Include the names, addresses, and telephone numbers requested.
3. The patient or legal representative of the patient/applicant signs the form.
4. Mail this form or your letter to the address shown below. The appeal form or letter must be received within ten (10) business days of the date of the CMS program's ineligibility/denial notification.

Send the completed form to: Georgia Department of Public Health/Children Medical Services
ATTN: Children's Medical Services Program Manager
Georgia Department of Public Health
Maternal and Child Health Section
2 Peachtree Street, NW
Atlanta, GA 30303
Or via email at: Childrens.Medical@dph.ga.gov

If you are not mailing the appeal form or letter within 10 business days of the CMS Program's action, please answer the questions below.

1. Did you get a denial or cancellation notice? □ Yes □ No
   a. What was the postmark date on the envelope?
   _____
   b. When did you get the notice?
   _____
2. If you did not get a notice, how did you learn of the denial, cancellation, or action?

_____

3. Have you had any problems getting mail? □ Yes □ No
   a. If yes, what type of problems?
   _____
   b. If yes, were these problems reported to the post office? □ Yes □ No
4. Has your address changed? □ Yes □ No If yes, when? _____
   a. Did you tell the agency? □ Yes □ No If yes, when?
   _____
5. Reason you didn't file an appeal within 10 business days of the agency action?
   _____
   _____
   _____
   _____