



Request to Appeal Form

Please complete this form if you wish to utilize an impartial third-party reviewer to appeal the denial decision made by the RMPACE Interdisciplinary Team.

Instructions:

Complete and mail or fax this form, along with any *supporting documents* to:

Rocky Mountain Health Care Services
 Attn: Quality and Compliance Department
 2502 E Pikes Peak Ave. Suite 100, Colorado Springs, CO 80909

OR fax the form and supporting documents to: 719-314-0077 Attention:
Quality and Compliance Dept. by the appeal deadline on the Service Request Letter.

Contact Information:

Participant Name:		Appeal deadline:	
		<i>See Service Request Letter</i>	
Person Filing Appeal:	<input type="checkbox"/> Participant <input type="checkbox"/> Representative, <i>if applicable</i>		
Name of Representative, <i>If not the participant</i>			
Best Daytime Phone:			
Alternate Phone:			
Address:			

Appeal Options:

1.	Do you wish to <u>present your case orally</u> to the Third-Party Reviewer?	<input type="checkbox"/> NO <input type="checkbox"/> YES
	*If YES, who will present to the reviewer:	<input type="checkbox"/> Participant <input type="checkbox"/> Representative
	If phone is different than above, indicate here:	

2.	Do you feel you need an expedited review is needed because “your life, health, or ability to regain maximum function would be severely jeopardized, absent of the provision of the service in dispute?”*	<input type="checkbox"/> NO <input type="checkbox"/> YES
If Yes, please explain why:		
<i>*refer to Notice of Appeals Process for more information</i>		

3.	Do you request to continue any current services that are <u>in dispute</u> during the appeal process?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> Not applicable
<i>*If YES, remember that If the Appeal Review agrees with the denial, you may be liable to pay for the disputed services you received during the appeal.</i>		

Appeal Statement:	
If you wish to submit a written statement for the Third-Party reviewer regarding why you wish to appeal this denial, please use the space below. Include additional pages if desired.	
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Printed Participant/Representative Name: _____

Participant/Representative Signature: _____

Date signed: _____

Attachment: *Notice of Non-Discrimination and Accessibility*



Notice of Non-Discrimination and Accessibility

Rocky Mountain PACE complies with applicable Federal civil right laws and does not discriminate on the basis of race, religion, color, national origin, age, disability, or sex. Rocky Mountain PACE does not exclude people or treat them differently because of race, religion, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats, such as large print, audio, and accessible electronic formats;
- Provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need interpreter services call: 1-719-466-8777 or for TTY 1-800-659-2656; para asistencia en español llame al 1-719-466-8777 TTY 1-800-659-2656; Để trợ giúp Việt Nam gọi 1-719-466-8777 hoặc 1-800-659-2656 TTY.

If you believe that Rocky Mountain PACE has failed to provide these services or discriminated in another way on the basis of race, religion, color, national origin, age, disability, or sex, you can file a grievance with:

RMHCS Compliance Officer, 2502 E Pikes Peak Ave. Suite 100, Colorado Springs, CO 80909, 1-719-466-8777 or email CivilRights@rmhcare.org.

You can file a grievance in person, by mail, phone, or email. If you need help filing a grievance, the RMHCS Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201; 1-800-868-1019, 1-800-537-7697 (TDD). Complaint forms are provided on the following link: <http://www.hhs.gov/ocr/office/file/index.html>



English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-719-314-2327 (TTY: 1-800-659-2656).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-719-314-2327 (TTY: 1-800-659-2656).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-719-314-2327 (TTY: 1-800-659-2656).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-719-314-2327 (TTY: 1-800-659-2656)。

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오. 1-719-314-2327 (TTY: 1-800-659-2656).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-719-314-2327 (телетайп: 1-800-659-2656).

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-719-314-2327 (መስማት ለተሳናቸው: 1-800-659-2656)።

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف 2327-314-719-1). 2656-659-800-1: الصم والبكم.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-719-314-2327 (TTY: 1-800-659-2656).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-719-314-2327 (TTY: 1-800-659-2656).

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् | 1-719-314-2327 (टिटिवाइ: 1-800-659-2656).

Japanese

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1-719-314-2327 (TTY: 1-800-659-2656).

Cushite — Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-719-314-2327 (TTY: 1-800-659-2656).

Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با
2327-314-719-1 تماس بگیرید (TTY: 1-800-659-2656).

Ibo/Igbo

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-719-314-2327 (TTY: 1-800-659-2656).

Kru-Bassa

Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m̄ [Bàsɔ̀̀-wùdù-po-nỳ̀] jũ ní, nìí, à wuɖu kà kò d̀̀ò po-pò̀ò béìn m̄ gbo kpáa. Ɖá 1-719-314-2327 (TTY: 1-800-659-2656).

Yoruba

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-719-314-2327 (TTY: 1-800-659-2656).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-719-314-2327 (TTY: 1-800-659-2656).

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