Catholic Health
LIFE - Living Independently
For Elders

Catholic Health LIFE Program
Appeal Form 1604A

Participant Name: _____ Participant ID: _____

Date Received: _____ Time Received: _____

Person Filing Appeal: _____ Staff Completing Report: _____

Relationship to Participant: _____

How Reported: In Person ☐ Phone ☐ Mail ☐ E-Mail ☐

Describe your request and reason for your appeal: _____

_____

_____

_____

☐ I wish to request an expedited review because: _____

_____

Signature: _____ Date: _____

(If received verbally, IDT member to fill in, sign, and date)

Reason for Appeal

☐Denial or restriction (ltd authorization) of service including amount, type or level of service
☐Reduction, suspension or termination of previously authorized service
☐Failure to provide services in a timely manner
☐Failure of plan to act upon appeal of plan action in a timely manner
☐Failure of plan to act upon grievance or appeal of grievance in a timely manner
☐Other

☐Decreased Center Attendance
☐Denial of Enrollment
☐Dentures
☐Durable Medical Equipment
☐Glasses
☐Hearing Aide
☐Home Modification(s)
☐Increased Center Attendance
☐Increased Home Care
☐Involuntary Disenrollment
☐Medical Procedure

☐Medical Supplies
☐Nursing Facility Placement-Long Term
☐Nursing Facility Placement-Respite
☐Nursing Facility Placement-Short Term
☐Specialist Consultation or Visit
☐Surgical Procedure
☐Transportation
☐Other _____

Appeal Approved ☐ Appeal Denied ☐ Date of Appeal Determination: _____

Resolution: _____

_____

_____

Date Service Provided to Participant: _____

External Appeal Requested ☐

Participant Received Appeal Fact Sheet ☐ Yes ☐ No Date: _____

For Office Use Only:

Participant received verbal notification of decision ☐ Yes ☐ No Date: _____
Participant received written notification of receipt of appeal ☐ Yes ☐ No Date: _____
Participant received written notification of decision ☐ Yes ☐ No Date: _____