San Mateo Medical Center
A County System of Healthcare

FINANCIAL ASSISTANCE PROGRAMS
Step 1 Appeal: Individual Eligibility Review (IER)

The purpose of this form is to appeal a disenrollment or denial of eligibility from a financial assistance program, or to request a waiver or reduction of co-pays, fees or charges. This form along with a Patient Financial Worksheet and other supporting documents must be completed and returned to the address at the bottom of the form within 60 days of receiving written notice indicating the disenrollment or denial, or within 60 days of receipt of the bill for the fees, co-pays or charges.

Name: _____ Date: _____

Signature: _____ Phone Number: _____

Medical Record Number: _____ Address: _____

Date of Birth: _____

I am appealing a denial of eligibility for the following program: (check one <u>if applicable</u>)

- ☐ ACE
- ☐ ACE Fee Waiver
- ☐ Discounted Health Care Program (DHC)
- ☐ Charity Care Program

I am appealing a disenrollment from the following program: (check one <u>if applicable</u>)

- ☐ ACE
- ☐ ACE Fee Waiver
- ☐ Discounted Health Care Program (DHC)
- ☐ Charity Care Program

I am requesting a waiver or reduction of co-pays, fees or charges for the following program: (check one <u>if applicable</u>)

- ☐ ACE
- ☐ Discounted Health Care Program (DHC)
- ☐ Self-pay

For which co-pay, fee or charge are you requesting a waiver/reduction? (Please attach copy of bill(s) for the fees, co-pays, or charges) _____

Please describe what you would like to gain as a result of the appeal as well as your basis for appeal (Be as specific as possible. You must also complete a Patient Financial Worksheet and attach any supporting documents and information that supports your position, including inability to pay information. Use backside of form if necessary):

_____

_____

Please submit this form along with a completed Patient Financial Status Worksheet and other supporting documentation within 60 days to: Kathy Van Kirk, Appeals Coordinator, Human Services Agency, 2500 Middlefield Road, Redwood City, CA 94063. San Mateo Medical Center will provide you with a written decision within 30 days after receiving this appeal form. If your appeal is denied, you have the right to take your appeal to the Eligibility and Financial Review Committee (EFRC).

If you have any questions about the appeals process, please contact the Appeals Coordinator at (650) 363-4482.

If you need help with this appeal, you may contact Legal Aid Society of San Mateo County
330 Twin Dolphin Drive, Suite 123, Redwood City, CA 94065; (650) 558-0915 for free legal assistance.