



Participant Appeal Form

You, as a participant and/or representative, have the right to appeal any treatment decision made by the Thome PACE staff. All of us at Thome PACE share responsibility for your care and your satisfaction with the services you receive. We welcome your input; through analyzing participant appeals, there is an opportunity for Thome PACE to improve or maintain the delivery of services and participant care.

Definition: An appeal is defined as the action taken with respect to Thome PACE's non-coverage of, or nonpayment for, a service, including denials, reductions or termination of services.

Instructions: Please complete this form to request an appeal of our decision to deny, defer, or modify a service or payment of a service that you or your representative requested. Send the completed form to the address below or contact a Thome PACE social worker for assistance with completing the form and/or gathering supporting information that you wish to be reviewed with your appeal. An impartial third party, not involved in the initial decision-making process, will review your appeal.

Thome PACE (attn: Social Worker)
2282 Springport Road
Jackson, MI 49202

Participant Name: _____ **Date:** _____

Representative Name/Relationship: _____ **Contact info:** _____

Requested Appeal Type: ☐ Standard ☐ Expedited / **Reason:** _____

DESCRIPTION of BENEFITS(s) / SERVICES(s) DENIED by IDT:

REASON FOR APPEAL: (**please include any/all supporting information/evidence you feel is relevant to your appeal and wish to have reviewed with the appeal request – this information can be shared by you either in-person or in writing)

I understand that Thome PACE will continue to provide me with the disputed service during the appeal process, and that I may be financially responsible if the appeal is not in my favor: ☐ Yes ☐ No

I have been given a reasonable opportunity to present evidence related to the dispute, in person, as well as in writing. (CFR 460.122) ☐ Yes ☐ No

Participant/Representative Signature: _____ **Date:** _____

Thome PACE staff assisting with Appeal Request: _____ **Date:** _____

Rec'd by Executive Director: _____

Rec.d by Quality Director: _____

External Entity: _____

Date Sent: _____

Decision Date: _____

Thome Decision Upheld: ☐ Yes ☐ No

Resolution Letter Sent: _____ (not to exceed 30 days from the date of the appeal request)

Accepted by Participant: ☐ Yes ☐ No (If no, attach any additional documentation to this form)

of days to resolve: _____

_____ **uploaded to EMR**

CMS/HPMS CONTROL # _____

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