APPENDIX C
FINANCIAL ASSITANCE APPEAL FORM

REQUEST FOR RE-EVALUATION ON FINANCIAL ASSISTANCE DENIAL

**General Information**

Date:
Name of Patient:
Date of Birth:
Address:
City, State, Zip Code:
Phone Number:

Guarantor Name (if different than patient):
Relationship:
Date of Birth:
Guarantor Address:
City, State, Zip Code:
Phone Number:

Please list reason of your request to appeal your Financial Assistance Denial (*Appeal letter must include supporting documents that may prove inability to pay that was not part of the initial consideration*):

____________________________________________________________________________

Please submit your appeal letter and supporting documents in person or by mail to PO BOX 1150 Vail, CO 81658, addressed to Patient Financial Services Director. You will receive a determination of your request to re-evaluate the denial decision of your Financial Assistance application within thirty days after receiving your appeal letter with appropriate supporting documents.

If you have any questions please contact one of our Financial Counselors at (970) 477-3116 or our Patient Financial Services Director at (970) 777-2840.

Thank you for choosing Vail Health as your health care provider.