Iowa Department of Health and Human Services
Behavioral Health and
Disability Services Appeal

### INSTRUCTIONS

This form gives us the information needed to help you with your appeal. Please fill out each part of this form. Describe the issue(s) in as much detail as possible.

If you have information you want to include with this form, attach copies. (Do not send originals). For example, medical records or a note from your doctor, etc.

If you are a legal guardian or Power of Attorney filing an appeal for someone else, please send documentation showing this.

You can have someone else file your appeal for you with your written consent. This is called an Authorized Representative. Your Authorized Representative can be your provider, a relative, friend or even an attorney.

### HOW TO SUBMIT REQUEST

There are multiple ways to file an appeal. Choose the one that works for you:

* Email: appeals@hhs.iowa.gov
* FAX: (515) 564-4044
* Mail: Iowa Department of Health and Human Services, Appeals Bureau,
 321 E 12th Street, Des Moines, Iowa 50319

We will let you know in writing that we received your appeal.

Iowa Department of Health and Human Services
Behavioral Health and
Disability Services Appeal

### WHO IS REQUESTING THIS APPEAL?

[ ] Self [ ] Family Member [ ] Someone else

|  |  |  |
| --- | --- | --- |
| First NameClick or tap here to enter text. | Middle InitialClick or tap here to enter text. | Last NameClick or tap here to enter text. |
| Agency or Business Name, if applicableClick or tap here to enter text. |
| Mailing Address (include Apt, Unit or Lot Number, if applicable)Click or tap here to enter text. |
| CityClick or tap here to enter text. | StateClick or tap here to enter text. | Zip CodeClick or tap here to enter text. |
| Phone NumberClick or tap here to enter text. | Email AddressClick or tap here to enter text. |

### WHO IS THE APPEAL FOR?

|  |  |  |
| --- | --- | --- |
| First NameClick or tap here to enter text. | Middle InitialClick or tap here to enter text. | Last NameClick or tap here to enter text. |
| Mailing Address (include Apt, Unit or Lot Number, if applicable)Click or tap here to enter text. |
| CityClick or tap here to enter text. | State Click or tap here to enter text. | Zip CodeClick or tap here to enter text. |
| County of ResidenceClick or tap here to enter text. | Date of BirthClick or tap here to enter text. |
| Phone NumberClick or tap here to enter text. | Email AddressClick or tap here to enter text. |

### WHAT ARE YOU APPEALING? (Select all that apply)

|  |  |
| --- | --- |
| [ ] Behavioral Health Services(Non-Medicaid) | [ ] Disability Services(Non-Medicaid) |
| Other:  | Click or tap here to enter text. |

Tell us why you are appealing (1000-character limit):
Click or tap here to enter text.

### ADDITIONAL INFORMATION

Do you need help with your appeal because you are blind or hard of hearing? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| Tell us how we can help:  | Click or tap here to enter text. |

Do you want a language interpreter for your hearing? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
|  If yes, what language?  | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Signature of Person Who Filled Out This FormClick or tap here to enter text. | Date Click or tap here to enter text. |