



Colorado Covering Kids and Families

## CHP+ Appeals Process August 2011

This fact sheet describes the appeals process for Child Health Plan *Plus* (CHP+) denials regarding eligibility, enrollment, or cost sharing. Please be sure to review the entire CHP+ appeals process for yourself on the Colorado Department of Health Care Policy and Financing's (HCPF) website [here](#). Below is a brief summary.

### CHP+ Appeals Process

Denials regarding eligibility, enrollment, or cost sharing may be appealed to the CHP+ Eligibility Vendor, MAXIMUS.

- Appeals should be in writing and should clearly state what the applicant is appealing and why. Be sure to include the case number.
- Appeals should be sent to PO Box 929, Denver, Colorado 80201-0929. Applicants may also fax appeals to (303) 893-1780. Be sure to write "Attention: Appeals" on the mail or fax correspondence.
- Appeals must be received within 30 calendar days from the date the applicant or client receives notification about a decision with which he or she disagrees.
- The case will be reviewed for data-entry errors and if errors are present, eligibility will be re-determined once errors are corrected.
- The CHP+ Eligibility Vendor must review and process appeals within 30 calendar days of their receipt.
- The appeal decision must be communicated in writing to the applicant or client within 10 business days of the review.

### What happens if I disagree with the appeal decision?

If an applicant or client disagrees with the appeal decision, he or she may have the case reviewed by the Grievance Committee, an independent panel comprised of at least three people who have not been previously involved with the appeal. Instructions for initiating this process are listed on the appeal decision letter. Please note that you must file a formal written appeal and receive a decision before requesting a review by the Grievance Committee.

- The applicant or client will be contacted with the date of the Grievance Committee hearing and may attend in person or by telephone.
- The applicant or client may be represented by a person of their choosing (legal counsel, friend, family member, etc.).
- The applicant or client may have access to any documents that were used in making the decision that he or she is appealing.
- The applicant or client may request a translator.
- The decision of the Grievance Committee is final.

If the client is already enrolled in CHP+ and is appealing his or her re-determination, the benefits continue throughout the appeals process. If the appeal is unsuccessful and the client is denied continuing coverage, the client will NOT be liable for any services received during the appeal process.

*This is NOT the process to follow if the client is appealing a denial of benefits. The client should contact his or her Health Maintenance Organization (HMO) to find out the HMO's appeal process.*

## contacts

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