Patient Name: _____ MRN: _____

APPEALING OUR DECISION

To appeal a decision about your financial assistance application to the JHS Eligibility Appeal Director, please complete the information below. This form must be completed within 60 days of your visit to the eligibility center. Please submit any documents you have to support your appeal with this form.

I wish to appeal the eligibility center's decision for the following reason:

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Completed form should be mailed or faxed to:

Eligibility Appeals Director

Jackson Health System

Park Plaza East, First Floor

901 NW 17 Street, Suite K

Miami, FL 33136-1096

Fax: 305-355-5386

Once we receive your appeal, your application for financial assistance and any documents we receive from you will be reviewed. You will receive a response within 60 days from the receipt of your appeal.