Appeal Form – Application for Discount on Past Bills

Instructions

If the County of Santa Clara Health System (CSCHS) denied your **Financial Assistance Application for Patients Whose Bills for Hospital Services Went to Collections Between October 28, 2018, and December 31, 2021**, or if you believe you qualify for a higher discount, you may appeal by:

1. Filling out the second page of this form; and
2. Submitting your completed form (and any documents supporting your appeal) to the following address within **30 days** of the denial or decision you disagree with:

CSCHS Patient Access Department
770 S. Bascom Avenue
San José, CA 95128
Attention: Revenue Cycle Director

Your appeal should **explain why you disagree** with the initial denial or decision you received from CSCHS. For example, if you think we made a mistake or there is additional information we should consider, please let us know.

You may submit supporting documents along with your completed appeal form. CSCHS may also contact you to request that you submit additional documents and/or information about your appeal.

CSCHS will make a decision on your appeal within 30 days of receiving your completed appeal form. If the initial denial or decision is upheld, you may submit a second appeal by completing another copy of this form and submitting it (and any supporting documents) to the following address within **30 days** of the denial of your first appeal:

CSCHS Patient Access Department
770 S. Bascom Avenue
San José, CA 95128
Attention: Chief Financial Officer

CSCHS will make a decision on any second appeal within 30 days of receiving your completed appeal form. The decision on any second appeal will be final.

If you have any questions or need help filling out this form, please contact the Patient Access Department by phone at 1-408-494-7850 or 1-888-524-3317 (TTY: 711) (8am to 4:30pm, Monday to Friday), by e-mail at FinancialAssistance@hhs.sccgov.org, or in person at 770 S. Bascom Avenue, San José, CA 95128 (8am to 4:30pm, Monday to Friday). You can also call the Health Consumer Alliance, a network of community-based legal services that will help you understand this form without cost, at 1-888-804-3536 (TTY: 711).

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Required Information

Please **complete all the fields below** before submitting this appeal form to CSCHS. Providing incomplete information may result in a delay or denial of your appeal.

Patient or Guarantor Name (Last, First, Middle):	
Date of Birth (month/day/year):	**Medical Record Number (if known):**
E-mail Address:	☐ **Check here to consent to receive communications regarding this appeal by secure e-mail**
Phone Number:	**Mailing Address:**
Date of Denial or Decision You Disagree With:	
Explain Why You Disagree with the Denial or Decision and What Relief You Are Requesting (if you need more space, please submit additional pages with this form):	

I affirm that the information I have provided is true and correct.

_______________ ____

Date Signature