VERMONT

PSHA Appeal Request for Service Denials

Member Name: _____

Medicaid ID #: _____

Preferred way of contacting you?

☐Phone: _____

☐Email: _____

☐Mailing Address: _____

Date of Decision (date you received notice that your services were denied): _____

Reason for Appeal (tell us what you do not agree with)

Do you want us to continue your coverage while you appeal?

☐Yes ☐No

Do you have an immediate need for these health services (expedited appeal)?

☐Yes ☐No

Submit appeal requests to the PSHA program manager:

Email: AHS.DCFOEOPSH@vermont.gov

Call: 802-863-6354

Mail: Permanent Supportive Housing
Office of Economic Opportunity
280 State Dr
Waterbury, VT 05671