Health Insurance Marketplace

Form Approved
OMB No. 0938-1207

# Appeal Request Form

This form is for Marketplace appeals in the following states and the District of Columbia:

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|---|---|---|---|---|
| **Alaska** | **Georgia** | **Maryland** | **New Hampshire** | **Rhode Island** |
| **Arizona** | **Hawaii** | **Massachusetts** | **New Mexico** | **South Carolina** |
| **California** | **Illinois** | **Michigan** | **New York** | **South Dakota** |
| **Colorado** | **Indiana** | **Minnesota** | **North Carolina** | **Utah** |
| **Connecticut** | **Iowa** | **Mississippi** | **North Dakota** | **Vermont** |
| **Delaware** | **Kansas** | **Missouri** | **Ohio** | **Virginia** |
| **District of Columbia** | **Kentucky** | **Nebraska** | **Oklahoma** | **Washington** |
| **Florida** | **Maine** | **Nevada** | **Oregon** | |

To get an Appeal Request Form for Marketplace appeals in other states, go to **HealthCare.gov/can-I-appeal-a-marketplace-decision**

To file an appeal, fill out this form and mail it here:

**Health Insurance Marketplace**
**465 Industrial Blvd.**
**London, KY 40750-0061**

You can also file an appeal by calling the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. **Requesting an appeal is time sensitive. Please review your eligibility notice to find appeals instructions specific to each person in your household, including the timeframe in which each person can request an appeal.** Your eligibility may change as a result of your appeal and, in some cases, your family members' eligibility may change as well, even if they don't file their own appeal.

You can appeal if you think we made a mistake about your or your family members' eligibility (see page 2 for more information). For example, you can appeal if you think we determined your eligibility incorrectly because we made a mistake about your income, household size, citizenship, immigration status, or residency. If multiple members of your household wish to appeal their determinations on your eligibility notice, list their names below so we know whose determination(s) are being appealed.

**Please keep a copy of all forms for your records.**

## APPELLANT 1

(An "appellant" is a person requesting an appeal. This section should be filled out by the person requesting the appeal or by a parent/guardian.)

| 1. First name | Middle name | Last name | Suffix |
|---|---|---|---|
| | | | |

| Date of birth (mm/dd/yyyy) | Phone number |
|---|---|
| | |

| Email address |
|---|
| |

| Street address | Apt./Ste. # |
|---|---|
| | |

| City | State | ZIP code |
|---|---|---|
| | | |

**List names of other household members who are filing an appeal using this form.**

**Name(s)***

**APPELLANT 2:** _____

**APPELLANT 3:** _____

**APPELLANT 4:** _____

* **If there are additional people in your household who want to file an appeal using this form, please attach a separate piece of paper with their names.**

## Reasons for filing an appeal

Your eligibility notice explains what you qualify for and the programs for which you don't qualify. Depending on your eligibility results, you may appeal:

- A denial of eligibility for purchasing health coverage, including eligibility to purchase a catastrophic health plan through the Marketplace.
- A denial of eligibility for tax credits or cost-sharing reductions to help pay for coverage through the Marketplace.
- The amount of tax credits or cost-sharing reductions you were determined eligible to receive through the Marketplace.
- A denial of eligibility for a Marketplace enrollment period.
- A denial of eligibility for an exemption from the individual responsibility requirement.

Date of eligibility notice (located on the upper right corner of your eligibility notice) (mm/dd/yyyy)

Date of a state's appeal decision (if you already received an appeal decision notice from your state-based Marketplace and want to appeal the decision) (mm/dd/yyyy)

## Explain the reason for your appeal.

If you're appealing for more than one appellant, list each name along with the reason for that appellant's appeal. Your explanation should include the reason you think we made a mistake. Add additional pages if needed.

## Authorized representative (if applicable)

You may have a relative, friend, legal counsel, or another spokesperson, including an authorized representative, help you file an appeal or participate in your appeal.

If you choose to name an authorized representative, you're giving this person permission to talk with us about your appeal.

**If you want to name an authorized representative, but haven't done so yet,** complete the authorized representation application in Appendix C and mail it in with this Appeal Request Form. You can also log into your Marketplace account, or call the Marketplace Call Center at 1-800-318-2596.

**If you already named an authorized representative, fill out the section below with his or her information.** If there's more than one authorized representative for the appellants you listed above, attach a separate page and provide the information in the box below for each authorized representative.

| Name of your authorized representative (First name, Middle name, Last name) | |
|---|---|
| Phone number | Email address (optional) |
| Organization name (if applicable) | |
| Street address | Apt./Ste. # |
| City / State / ZIP code | |

## Authorization to disclose federal tax and Social Security information for use during an appeal

During your appeal, you may want to share the information we used to make your eligibility determination. This information might include federal tax information from the Internal Revenue Service (IRS), including information from your last filed federal income tax return or income you get from Social Security, like:

- Your filing status and whether or not an income tax return was filed
- The number of dependents claimed on your return
- Other information provided by law to determine eligibility for financial assistance to pay for health insurance premiums and to reduce out-of-pocket costs for health care services
- Your income information
- Your current monthly Social Security Benefit amount
- The number of health care quarters of coverage you've obtained

**The Marketplace can't disclose federal income tax information or income information from Social Security without your authorization. You give your authorization for this disclosure by signing on page 4.**

## Read and sign below

The information in this section applies for all people signing below, including the appellant(s) and all other adults in the appellant's(s') household.

I understand that by completing, signing, and dating below, I authorize the Marketplace to disclose federal tax information from the IRS and income information from Social Security collected based on my application and from other data sources that may have been used to make the eligibility determination. I understand that this information may be disclosed for use during the appeals process. Each adult member of the household must authorize the disclosure of his or her own federal tax and Social Security income information by signing below or on a separate form. The authorization is valid until the appeal is concluded or I notify the Marketplace otherwise.

I understand by completing, signing, and dating below, I authorize the Marketplace to disclose federal tax information from the Internal Revenue Service and income information from the Social Security Administration along with other information in my eligibility record, collected based on the application I filled out, and from other data sources that may have been used to make the eligibility determination, to my authorized representative and other household members whose signatures are provided below. I understand I may request a copy of my eligibility record during the appeals process. Each adult member of the household must authorize the disclosure of his or her own federal tax information and Social Security Administration income information by signing below or on a separate form. The authorization is valid until the appeal is concluded or I notify you otherwise.

I'm signing this form under penalty of perjury, which means I've provided true answers to all the questions I have answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

I understand that I'm not required to complete this form. I'm voluntarily completing it for the purpose of making an appeal to the Marketplace.

## Signature of appellant 1 only (or parent, guardian, or authorized representative, if applicable)

I understand that I'm the primary contact for purposes of appealing these eligibility determinations.

| Printed name of appellant 1 (or parent, guardian, or authorized representative, if applicable) (First, Middle, Last) |
|---|
| |

| Relationship to appellant 1 (if applicable) |
|---|
| |

| Signature of appellant 1 (or parent, guardian, or authorized representative, if applicable) | Date of signature (mm/dd/yyyy) |
|---|---|
| | |

## Additional signatures of adults in household

All adults listed on the initial eligibility application who are 18 and older, whether or not listed as appellants on this form, must also provide a signature to authorize the release of their federal tax and Social Security income information for the purposes of this appeal.

| Printed name of appellant 2 **or** of an adult in the household (if applicable) | Date of birth (mm/dd/yyyy) |
|---|---|
| Signature of appellant 2 or of the adult in the household (if applicable) | Date of signature (mm/dd/yyyy) |

| Printed name of appellant 3 **or** of an adult in the household (if applicable) | Date of birth (mm/dd/yyyy) |
|---|---|
| Signature of appellant 3 or of the adult in the household (if applicable) | Date of signature (mm/dd/yyyy) |

| Printed name of appellant 4 **or** of an adult in the household (if applicable) | Date of birth (mm/dd/yyyy) |
|---|---|
| Signature of appellant 4 or of the adult in the household (if applicable) | Date of signature (mm/dd/yyyy) |

## Next steps

1. **We'll send you confirmation of your appeal request and further instructions:** We'll also send you a letter letting you know that we received your appeal request. This notice will also provide you with an explanation of your health coverage while your appeal is pending. If there's a problem with your appeal request, like if it's missing information or we need clarification, we'll inform you and permit you to correct the issue within a specific timeframe.
2. **Review of your information:** We'll review your appeal request and any additional information you submit, along with the information we used to originally determine your eligibility. We may contact you to request additional information or to discuss your appeal. You have the right to review the information being used to resolve your appeal, including the information in your electronic account.
3. **Informal resolution:** We may be able to resolve your appeal informally, by reviewing all of your information and discussing it with you. After reviewing all your information and discussing your appeal with you, as necessary, we'll send you an informal resolution decision that explains your eligibility for health coverage. If you're satisfied with this informal resolution decision, we'll implement the decision and close your appeal. In this case, you wouldn't have a hearing.
4. **Hearing:** If you disagree with the informal resolution decision, you can continue your appeal at a hearing. A hearing is a formal meeting involving you and a hearing officer where you can explain why you think we made a mistake with your eligibility determination.

   Your hearing may take place over the phone. You can participate in the hearing by yourself or have someone participate in your hearing with you. This person can be a friend, relative, lawyer, your authorized representative (if you have one), or another individual. You have the right to provide additional information to the hearing officer for consideration before or at the time of the hearing. You also have the right to review all the information that the hearing officer will be considering for your appeal, including any information in your Marketplace account. After the hearing, the hearing officer will review all your information and make a final decision about your appeal, which will be mailed to you.

## Submitting additional information

You can submit additional information to support your appeal. Any information you submit will be reviewed along with the information you submitted on your application and that was used to make your eligibility determination. You may submit additional information by attaching it and returning it with this form or by mailing it here separately:

**Health Insurance Marketplace**
**465 Industrial Blvd.**
**London, KY 40750-0061**

If you mail it separately, include the complete contact information of appellant 1 (as it appears on this form), including name, date of birth, phone number, email address (optional), and address. If there are multiple appellants listed on this form, identify the specific appellant(s) whose appeal(s) the additional information supports.

## Requesting an expedited appeal

If you have an immediate need for health services and a delay could seriously jeopardize your health, you can ask for an expedited appeal by calling the Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. Visit HealthCare.gov for more information on the expedited appeal process.

## Health coverage during your appeal

You may be able to keep your eligibility for coverage while your appeal is pending. If your appeal request is accepted, we'll notify you if you qualify to keep your eligibility while your appeal is pending.

## Language assistance services

If you need language assistance in a language other than English, you have the right to get help and information in your language at no cost. Call the Marketplace Call Center at 1-800-318-2596 to access these language assistance services.

## Accessibility

If you have a disability and need a reasonable accommodation, log into your Marketplace account or call the Marketplace Call Center at 1-800-318-2596 to request accommodations. These accommodations are available and provided at no cost to you.

## Where can I find more information?

Go to **HealthCare.gov/can-i-appeal-a-marketplace-decision**, or call the Marketplace Call Center at 1-800-318-2596.

## Privacy and use of your information

We'll keep your information private as required by law. For more information, read the Privacy Act Statement included with this form.

## Privacy Act Statement

We are authorized to collect the information on this form and any supporting documentation, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111–152) and the Social Security Act.

We need the information provided by you and the other individuals listed on this form to process your eligibility appeal request for: (1) enrollment in a qualified health plan through the Federal Health Insurance Marketplace, (2) for insurance affordability programs, and (3) for certifications of exemption from the individual responsibility requirement. As part of that process, we will review all information provided on the form, may verify any new information gathered through the appeals process, and communicate with you or your authorized representative. We will also use the information provided as part of the ongoing operation of the Marketplace, including activities such as verifying continued eligibility for all programs, reporting on and managing the insurance affordability programs for eligible individuals, performing oversight and quality control activities, combatting fraud, and responding to any concerns about the security or confidentiality of the information.

While providing the requested information (including Social Security numbers) is voluntary, failing to provide it may delay or prevent your ability to obtain health coverage through the Marketplace, advanced payment of the premium tax credits, cost sharing reductions, or an exemption from the shared responsibility payment. If you don't have an exemption from the shared responsibility payment and you don't maintain qualifying health coverage for three months or longer during the year, you may be subject to a penalty. If you don't provide correct information on this form or knowingly and willfully provide false or fraudulent information, you may be subject to a penalty and other law enforcement action.

In order to verify and process an appeal request, determine eligibility, and operate the Marketplace, we will need to share selected information that we receive outside of CMS, including to:

1. Other federal agencies, (such as the Internal Revenue Service, Social Security Administration, Department of Homeland Security and the Health and Human Services appeals entity), state agencies (such as Medicaid or CHIP), or local government agencies. We may use the information you provide in computer matching programs with any of these groups to make eligibility determinations or to verify continued eligibility for federal benefit programs;
2. Judicial review entities at the state or federal level as available by law;
3. Applicants/enrollees and authorized representatives of applicants/enrollees;
4. CMS contractors engaged to perform a function for the Marketplace; and
5. Anyone else as required by law or allowed under the Privacy Act System of Records Notice associated with this collection (CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, 78 Federal Register, 8538, March 6, 2013, and 78 Federal Register, 32256, May 29, 2013).

This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)). You can learn more about how we handle your information at **HealthCare.gov**.

# APPENDIX C

Form Approved
OMB No. 0938-1191

## Assistance with completing this application

**You can choose an authorized representative.**

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

**For certified application counselors, navigators, agents, and brokers only.**

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number