Health Insurance Marketplace

Marketplace Appeal Request Form

- Include any documents you have to help your appeal (Step 4).
- Have all tax filers on the application sign the form (Step 5).
- **Mail or fax this form within 90 days of the date on the Marketplace Eligibility Notice you're appealing.**

Person filling out this form: First name | **Last name**

STEP 1 Whose eligibility is being appealed?

Include ONLY the people on your application whose eligibility is being appealed. (Use extra paper to add more names)

Person 1 appealing

Person 1's First name | **Last name**

Date of birth (mm/dd/yyyy) / / | **Daytime phone number** ( ) -

Street address | **Apartment or suite number**

City | **State** | **ZIP code**

Person 2 appealing

Person 2's First name | **Last name**

Date of birth (mm/dd/yyyy) / /

Person 3 appealing

Person 3's First name | **Last name**

Date of birth (mm/dd/yyyy) / /

Person 4 appealing

Person 4's First name | **Last name**

Date of birth (mm/dd/yyyy) / /

STEP 2 Reason for the appeal

Application ID # (printed on the first page of the Marketplace Eligibility Notice)

Date on the Notice (mm/dd/yyyy)

/ /

What Marketplace decision(s) are you appealing? *(Select all that apply)*

- ☐ Not eligible for financial help, including advance payments of the premium tax credit or help with cost-sharing
- ☐ Eligible for advance payments of the premium tax credit, but the amount is wrong
- ☐ Not eligible for a Special Enrollment Period to enroll in or change your Marketplace plan
- ☐ Not eligible to buy a Marketplace plan
- ☐ Not eligible to choose a Catastrophic plan
- ☐ Not eligible for an exemption from the requirement to have health insurance
- ☐ Other:

Explain why you think the Marketplace decision is incorrect.

If you're appealing a Marketplace Eligibility Notice dated more than 90 days before today, please also explain the delay in filing this appeal.

STEP 3 Do you need to fast-track ("expedite") your appeal for a health reason?

If you think waiting for a standard decision may seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, you can ask for a fast (expedited) appeal. (For example, if you're currently in the hospital or urgently need medication.)

◯ **Yes, I need to expedite my appeal.** Please explain the reason you need an expedited appeal.

STEP 4 Include documents to help your appeal (optional)

- You may want to submit documents with your request to help show why you think the Marketplace decision was incorrect. Submit any documents you think will help your case.
- This could be things like tax returns, pay stubs, W2 forms, passports, or other documents that show your income or prove other information.
- See a full list of possible documents at **HealthCare.gov/verify-information/documents-and-deadlines/**.
- **Submit copies, not originals, since your documents won't be returned.**

◯ **Yes, I'm including documents to help my appeal.**

Appealing a Marketplace decision because of missing information about your taxes?

Submit a Record of Account Transcript and a copy of IRS Form 8962, if you filed it. Visit **IRS.gov/individuals/get-transcript** or call the IRS at 1-800-908-9946 to get these documents.

STEP 5 Signatures of ALL tax filers age 18 and older on your Marketplace application (even if they're not appealing)

Your approval to let the Marketplace share federal tax information and Social Security Administration information for use during an appeal.

During your appeal, we may need to share with you or your authorized representative the information the Marketplace used to determine your eligibility. This information might include employment income information from a consumer reporting agency, information about income you receive from the Social Security Administration, and federal tax information from the Internal Revenue Service about members of your household, including information from your last filed federal income tax return. The Marketplace can't share federal income tax information or monthly and annual Social Security Benefit information under Title II of the Social Security Act from the Social Security Administration to an authorized representative or other individuals without your consent. Sign below to give your consent.

I understand by completing, signing, and dating below, I authorize the Marketplace to disclose to the individuals whose signatures are provided below as well as any authorized representative any federal tax information in my eligibility record which was provided by the Internal Revenue Service. I also consent to the release by the Marketplace of my monthly and annual Social Security Benefit information under Title II of the Social Security Act to these same individuals along with other information in my Marketplace eligibility record, collected based on the application I filled out (or was completed for me) or that listed me as a household member, and from other data sources like income and employment verification from a consumer reporting agency that were used to make the Marketplace eligibility determination.

I understand I can request a copy of my Marketplace eligibility appeal record during the appeals process. Each adult member of the household must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

The authorization is valid until the earlier of the resolution of the appeal; or my written notification that I want any or all of my authorized representatives removed from this appeal. I'm signing this form under penalty of perjury, which means I've provided true answers to all the questions, and I've answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

Signatures of all tax filers on your Marketplace application age 18 and older

1. Printed name (First name, Last name)

Signature **Date (mm/dd/yyyy)** / /

2. Printed name (First name, Last name)

Signature **Date (mm/dd/yyyy)** / /

3. Printed name (First name, Last name)

Signature **Date (mm/dd/yyyy)** / /

4. Printed name (First name, Last name)

Signature **Date (mm/dd/yyyy)** / /

STEP 6 Get electronic updates (optional)

Get updates about your appeal from the Marketplace Appeals Center. Notifications will not contain personal health information.

Text to mobile number

( )

Email

STEP 7 Mail or fax your appeal request

Mail or fax your appeal request, along with any supporting documents, within 90 days of the date on the Notice you're appealing.

Mailing address:

Health Insurance Marketplace, Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061

Secure fax line:

1-877-369-0130

The Marketplace Appeals Center will send you a notice confirming receipt of your appeal and giving more information about the appeal process within 7-10 business days.

Do you need an authorized representative? (optional)

- You have the right to choose an authorized representative to help with your appeal.
- An authorized representative can be a friend, family member, or someone else you trust.
- This person will act for you on all matters related to your appeal.
- **All communications about your appeal (including emails and text reminders) will go to this person, not you.**
- If you change your mind, you must call or write the Appeals Center to remove your authorized representative.

Authorized representative First name

Last name

Date of birth (mm/dd/yyyy)

/ /

Daytime phone number

( )

Street address

Apartment or suite number

City

State

ZIP code

Organization name

ID number (if applicable)

Get electronic updates (optional)

Get updates about your appeal from the Marketplace Appeals Center. Notifications will not contain personal health information.

Text to mobile number

( )

Email

By signing, you allow this authorized representative to sign your Appeal Request Form, get official information about this appeal, and act for you on all future matters related to this appeal. If you're appealing only for yourself, Person 1 listed on this appeal form signs here. If you're appealing for more than one person in your household, your Marketplace application filer signs here.

Signature of PERSON 1 listed on this appeal form OR of the Marketplace application filer

Date (mm/dd/yyyy)

/ /

Privacy & Use of Your Information

The Marketplace protects the privacy and security of information about you that you've provided. To view the Privacy Act Statement, go to **HealthCare.gov/individual-privacy-act-statement**. We're 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), implementing regulations in 45 CFR part 155, subpart F, and the Social Security Act. For more information about the privacy and security of your information, visit **HealthCare.gov/privacy**.

Nondiscrimination

The Health Insurance Marketplace doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting **hhs.gov/ocr/civilrights/complaints**, or writing to the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.