Health Insurance Marketplace

OMB Exempt

Marketplace Eligibility Appeal Request

- Submit this form within 90 days of the date on the Marketplace Eligibility Notice you're appealing.
- Have the tax filer on the Marketplace application sign the form (Step 8).
- Include any documents you have to help your appeal (Step 9).

Person filling out this form:

First name: **Middle name:** **Last name:**

STEP 1 Whose eligibility is being appealed?

Only include the people on your Health Insurance Marketplace® application whose eligibility is being appealed.

Person 1

First name: **Middle name:** **Last name:**

Date of birth (mm/dd/yyyy): **Email:**

Daytime phone number:

Street address: **Apartment or suite number:**

City: **State:** **ZIP code:**

Person 2

First name: **Middle name:** **Last name:**

Date of birth (mm/dd/yyyy): **Email:**

Person 3

First name: **Middle name:** **Last name:**

Date of birth (mm/dd/yyyy): **Email:**

Person 4

First name: **Middle name:** **Last name:**

Date of birth (mm/dd/yyyy): **Email:**

STEP 2 Reason for the appeal

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

Notice Date (mm/dd/yyyy):

On HealthCare.gov, you said you're appealing because the Marketplace said you're not eligible for savings (premium tax credit or cost savings) or because you don't agree with the amount of financial help the Marketplace said you qualify for.

Explain why you think the Marketplace decision is wrong. The more information you provide here, the faster we can resolve your appeal.

If you're filing this appeal more than 90 days after the date on the Marketplace Eligibility Notice you're appealing, also explain the delay in filing your appeal.

STEP 3 Information about your household (optional)

Giving us your household information now can speed up your appeal. Make sure you answer for the coverage year you're appealing.

Attach additional pages if you need more space (Step 9).

1. Who needs Marketplace coverage? Include everyone in your household or family that needs Marketplace coverage, even if they didn't apply for coverage on the Marketplace Eligibility Notice you're appealing.

Name: **Name:**

Name: **Name:**

Name: **Name:**

2. What tax filing status will you use?

- ☐ I won't file a federal income tax return.
- ☐ Single.
- ☐ Married filing jointly.
- ☐ Married filing separately.
- ☐ Head of household.
- ☐ Someone else will claim me as a dependent on their tax return.

3. How many people will you report on your tax return, including yourself? Count yourself, your spouse if you're married, and everyone you'll claim as a tax dependent, including those who don't need coverage.

Number of people:

4. What do you expect your annual household income will be? Count income for you, your spouse, and everyone you'll claim as a dependent on your federal tax return (if the dependents are required to file). Include their income even if they don't need health coverage. For help estimating income, visit HealthCare.gov/income-and-household-information.

Estimated total annual household income: $

5. Is anyone who needs coverage eligible for or enrolled in health coverage outside of the Marketplace? Other types of health coverage include Medicaid, CHIP, Medicare, Veterans Affairs (VA) health care program, TRICARE, Peace Corps, COBRA, retiree health benefits, and coverage through a job or an individual coverage Health Reimbursement Arrangement (HRA).

☐ No. ☐ Yes, the person (or people) listed below are eligible for or enrolled in other health coverage.

Name:	**Type of coverage:**
Name:	**Type of coverage:**
Name:	**Type of coverage:**
Name:	**Type of coverage:**
Name:	**Type of coverage:**
Name:	**Type of coverage:**

6. Is anyone who needs coverage pregnant?

☐ No. ☐ Yes, the person (or people) listed below are pregnant.

Name: **Name:**

Name: **Name:**

7. Did you get a notice from the Marketplace about Open Enrollment starting November 1? It typically arrives in the fall.

☐ No. ☐ Yes. ☐ I don't know.

STEP 4 Do you need to fast-track ("expedite") your appeal for a health reason? (optional)

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, you might qualify for an expedited appeal if you're currently in the hospital or urgently need medication).

Do you need to expedite your appeal?

☐ No.

☐ Yes. Please explain the reason you need an expedited appeal.

STEP 5 Get electronic updates (optional)

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

By entering your number below, you agree to get text messages from the Marketplace Appeals Center. Message frequency varies and message data rates may apply. Visit HealthCare.gov/appeals/en/terms-and-conditions and HealthCare.gov/privacy for more information.

Text to mobile number:

Email:

STEP 6 Appoint a representative (optional)

You can choose to have someone you trust (like a family member, friend, advocate, or attorney) act on your behalf for your appeal by giving them permission to be your authorized representative.

If you appoint an authorized representative, they'll be the main contact during your appeal. All communications about your appeal (including email and text reminders) will go to your authorized representative, not you.

Do you want to appoint a representative?

☐ **No. Go to Step 7.**

☐ **Yes. Fill out the section below.** If you change your mind, you must call or write the Marketplace Appeals Center to remove your authorized representative.

First name: **Middle name:** **Last name:**

Date of birth (mm/dd/yyyy): **Email:**

Daytime phone number:

Street address:

Apartment or suite number:

City: **State:** **ZIP code:**

Organization name: **ID number (if applicable):**

Text updates to mobile number (optional): **Send email updates to (optional):**

Sign below to give the person listed in this section permission to sign your appeal request, get official information about your appeal and act for you during your appeal.

Printed name (First name, Middle name, Last name)

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

STEP 7 Keeping your financial help during your appeal (optional)

You may be able to keep the same level of financial help ("continuation of benefits") while your appeal is reviewed.
Would you like to keep your financial help during your appeal?

☐ **Yes, I want my financial help to stay the same until my appeal is decided.** I understand that if I lose my appeal, I may have to pay back some or all of the financial help I got when I file my taxes at the end of the year.

Apply my financial help to:
Enter your Marketplace plan name or plan ID:

☐ **No, I don't want to keep my financial help during my appeal.**

NOTE: You must continue paying your monthly premium to keep your current coverage. If your coverage ends because you stopped paying the premium, you might not be eligible to enroll in a Marketplace plan until the next Open Enrollment period, even if you win your appeal.

STEP 8 Signature

Sign below to let the Marketplace share federal tax information and Social Security Administration information for use during an appeal, and to give us permission to talk to your representative (if you appointed one) about your appeal.

During your appeal, we may need to share with you or your authorized representative the information the Marketplace used to decide 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 federalincome 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.

Signature of the tax filer listed on your Marketplace application (even if they're not appealing)

Printed name (First name, Middle name, Last name)

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

STEP 9 Submit 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 wrong. 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.**

STEP 10 How to submit your appeal

Sign the completed form and send your documents either:

- **By Mail:** Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London KY 40750-0061
- **By Secure Fax:** 1-877-369-0130

For More Help
If you have questions about your appeal call the Marketplace Appeals Center at 1-855-231-1751. TTY users can call 711. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET).

Language Assistance Services
If you need help with your appeal in a language other than English, you have the right to get information in your language at no cost. Call the Marketplace Appeals Center at 1-855-231-1751. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET).

Accessibility
To request appeal forms and notices in an alternate format like Braille, large print, data CD, audio CD, or to request a qualified reader, you can call the Marketplace Appeals Center at 1-855-231-1751. TTY users can call 711. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET). You can also make a request in writing by fax (1-877-369-0130) or mail (Marketplace Appeals Center, P.O. Box 311, Pittston, PA 18640). Accommodations are provided at no cost to you.

Privacy Act Statement
The Marketplace protects the privacy and security of information about you that you have provided. To view the Privacy Act Statement, go to HealthCare.gov/individual-privacy-act-statement/. This notice was generated by the Marketplace based on 45 CFR part 155, subpart F. The information used to create this notice was collected from the application you filled out, from your appeal request and other associated materials you may have submitted, and from other data sources through the electronic eligibility verification process to get an eligibility determination for enrollment in a qualified health plan through the Marketplace and insurance affordability programs. 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/civil-rights/filing-a-complaint/complaint-process, 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.

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This Notice has Important Information. This notice has important information about your application or coverage through the Health Insurance Marketplace®. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-318-2596 and wait through the opening. When an agent answers, state the language you need and you'll be connected with an interpreter.

لعربية (Arabic) يحوي هذا الإشعار على معلومات مهمة. يحوي هذا الإشعار على معلومات مهمة بخصوص طلبك أو تغطيتك عبر سوق التأمين الصحي (Health Insurance Marketplace®) إبحث عن التواريخ المهمة في هذا الإشعار. قد تحتاج إلى إتخاذ إجراء بحلول تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة بخصوص التكاليف. يحق لك الحصول على هذه المعلومات و على المساعدة بلغتك من دون أي تكلفة. إتصل بالرقم 1-800-318-2596 وانتظر حتى تنتهي الإفتتاحية. اذكر اللغة التي تحتاجها عندما يرد عليك العميل و سيتم وصلك بمترجم فوري.

中文 (Chinese) 本通知含有重要的訊息。本通知含有關於通過健康保險市場 (Health Insurance Marketplace®) 申請或獲得承保的重要訊息。請在本通知中查看重要的日期。您可能要在特定的截止日期之前採取行動，以保留您的健康保險或有助於省錢。您有權利免費以您的母語得到幫助和訊息。請致電 1-800-318-2596 並等待接聽。告訴服務代表要用的語言後，便會接通口譯員。

Français (French) Cet avis contient des informations importantes. Cet avis comporte des informations importantes relatives à votre demande ou à votre couverture par le marché de l'assurance maladie (Health Insurance Marketplace®). Prêtez attention aux dates importantes figurant dans cet avis. Il se peut que vous deviez prendre des mesures avant certaines dates limites pour conserver votre couverture médicale ou bénéficier d'une aide financière. Vous êtes en droit d'obtenir ces informations et cette aide dans votre langue, et ce gratuitement. Appelez le 1-800-318-2596 et patientez. Dès qu'un agent décroche, indiquez la langue dont vous avez besoin et vous serez mis en rapport avec un interprète.

Kreyòl (French Creole) Avi sa a gen Enfòmasyon Enpòtan. Avi sa a gen enfòmasyon enpòtan konsènan aplikasyon w lan ak pwoteksyon ou an atravè Health Insurance Marketplace®. Chèche dat kle yo nan avi sa a. Li posib pou pran desizyon avan sèten dat limit pou konsève pwoteksyon medikal ou oswa pou ede ak pri yo. Ou gen dwa pou jwenn enfòmasyon sa a ak èd nan lang ou gratis. Rele 1-800-318-2596 epi tann sou liy nan. Lè yon ajan reponn, di lang ou bezwen an epi y ap mete w an koneksyon avèk yon entèprèt.

Deutsch (German) Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder Ihrer Versicherung über den Health Insurance Marketplace®. Achten Sie auf die Eckdaten in dieser Mitteilung. Möglicherweise müssen Sie innerhalb bestimmter Fristen Maßnahmen ergreifen, um Ihren Krankenversicherungsschutz zu behalten oder sich an den Kosten zu beteiligen. Sie haben das Recht, die Informationen und Hilfen kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die Nummer 1-800-318-2596 an und warten Sie, bis das Gespräch angenommen wird. Wenn sich ein Mitarbeiter meldet, geben Sie die Sprache an, die Sie benötigen, und Sie werden mit einem Dolmetscher verbunden.

ગુજરાતી (Gujarati) આ સૂચનામાં અગત્યની માહિતી છે. આ સૂચનામાં તમારી આરોગ્ય વીમા બજાર (Health Insurance Marketplace®) દ્વારા કરવામાં આવેલ અરજી અથવા તેના દ્વારા આવરી લીધેલ જોખમ વિશે અગત્યની માહિતી છે. આ સૂચનામાં મુખ્ય તારીખો જુઓ. તમારા વીમા દ્વારા આવરી લીધેલ આરોગ્ય જોખમ અથવા ખર્ચમાં મદદને જાળવી રાખવા માટે તમારે ચોક્કસ સમયમર્યાદામાં પગલાં લેવાની જરૂર પડી શકે છે. તમને કોઈપણ ખર્ચ વિના તમારી ભાષામાં આ માહિતી અને મદદ મેળવવાનો અધિકાર છે. 1-800-318-2596 પર કૉલ કરો અને શરૂઆતમાં રાહ જુઓ. જ્યારે કોઈ પ્રતિનિધિ જવાબ આપે, ત્યારે તમને જોઈતી ભાષા જણાવો અને તમને અનુવાદક સાથે જોડવામાં આવશે.

Italiano (Italian) Questo avviso contiene importanti informazioni. Questo avviso contiene importanti informazioni sulla tua richiesta o copertura assicurativa attraverso il mercato delle assicurazioni sanitarie (Health Insurance Marketplace®). Questo avviso include date importanti. Potrebbe essere necessario un tuo intervento entro certe scadenze per mantenere l'assicurazione sanitaria o assistenza con i costi. Hai diritto ad ottenere queste informazioni e assistenza nella tua lingua a titolo gratuito. Chiama il 1-800-318-2596 e attendi la fine dell'introduzione. Quando un agente risponde, indica la linua di cui hai bisogno e sarai collegato a un interprete.

日本語(Japanese) この通知には重要な情報が含まれています。この通知には、健康保険マーケットプレイス(Health Insurance Marketplace®)経由のアプリケーションまたは補償範囲に関する重要な情報が含まれています。この通知では、重要な期日について確認してください。補償範囲や費用サポートを維持するには、指定の期日までにご対応いただく必要がある場合があります。これらの情報を無料で取得する権利および希望の言語でサポートを受ける権利があります。1-800-318-2596 にお問い合わせいただき、つながるまでお待ちください。エージェントにつながりましたら、必要とする言語をお伝え下さい。通訳者とつながります。



한국어 (Korean) 본 통지는 중요한 정보를 담고 있습니다. 본 통지는 건강보험 마켓플레이스(Health Insurance Marketplace®)를 이용한 신청 또는 보장에 대한 중요한 정보를 담고 있습니다. 본 통지에서 주요 날짜를 확인하십시오. 건강보험을 유지하거나 비용에 도움을 받기 위해 특정 마감일까지 조치를 취해야 할 수도 있습니다. 귀하에게는 이러한 정보를 받고 무료로 귀하의 언어로 도움을 받을 권리가 있습니다. 1-800-318-2596으로 전화하여 연결을 기다리십시오. 담당자가 연결될 때, 원하시는 언어를 알려주시면 통역자에게 연결됩니다.

Polski (Polish) Niniejsze zawiadomienie zawiera ważne informacje. Niniejsze zawiadomienie zawiera ważne informacje na temat Twojego wniosku lub zakresu ubezpieczenia za pośrednictwem rynku ubezpieczeń zdrowotnych (Health Insurance Marketplace®). Szukaj kluczowych dat w tym ogłoszeniu. Być może będziesz musiał/a podjąć działania w określonych terminach, aby utrzymać ubezpieczenie zdrowotne lub pomóc w pokryciu kosztów. Masz prawo do uzyskania tych informacji i pomocy w swoim języku bez żadnych kosztów. Zadzwoń pod numer 1-800-318-2596 i czekaj, aż skończy się wstępna informacja. Gdy włączy się agent, podaj język, który jest Ci potrzebny, a zostaniesz połączony z tłumaczem.

Português (Portuguese) Este aviso tem informações importantes. Este aviso tem informações importantes sobre sua solicitação ou cobertura por meio do mercado de seguros de saúde (Health Insurance Marketplace®). Procure as datas importantes neste aviso. Você pode precisar agir dentro de certos prazos para manter sua cobertura de saúde ou obter ajuda com os custos. Você tem o direito de obter essas informações e ajuda gratuitamente no seu idioma. Ligue para 1-800-318-2596 e espere o fim da gravação de abertura. Quando o agente responder, diga o idioma que você precisa e você será conectado(a) a um intérprete.

Русский (Russian) В этом уведомлении содержится важная информация. В этом уведомлении содержится важная информация о вашей заявке или страховом покрытии на портале Рынка медицинского страхования Marketplace (Health Insurance Marketplace®). Это уведомление содержит ключевые даты. Возможно, вам потребуется принять меры к определенным срокам, чтобы сохранить свою медицинскую страховку или помочь в покрытии расходов. У вас есть право получить эту информацию и помощь на вашем языке бесплатно. Позвоните по телефону 1-800-318-2596 и переждите вступительное сообщение. Когда агент ответит, укажите нужный вам язык, и вас соединят с переводчиком.

Español (Spanish) Este Aviso contiene Información Importante. Este aviso contiene información importante sobre su solicitud o su cobertura del Mercado de Seguros Médicos (Health Insurance Marketplace®). Preste atención a las fechas claves en este aviso. Usted podría tener que actuar dentro de ciertos plazos para mantener su cobertura médica u obtener ayuda con los costos. Tiene derecho a recibir esta información y ayuda en su idioma sin costo. Llame al 1-800-318-2596 y espere hasta el fin del mensaje inicial. Cuando un agente contesta, indique el idioma que usted necesita y será conectado con un intérprete.

Tagalog (Tagalog) Ang Paunawang ito ay mayroong mahalagang impormasyon. Ang paunawang ito ay mayroong mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Pamilihan ng Segurong Pangkalusugan (Health Insurance Marketplace®). Tingnan ang mga pangunahing petsa sa paunawang ito. Maaaring kailangan mong gumawa ng aksyon sa tiyak na mga huling araw upang mapanatili mo ang sakop sa kalusugan o makatulong sa mga gastos. Mayroon kang karapatan na makakuha ng ganitong impormasyon at ng tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-318-2596 at maghintay hanggang magbukas. Kapag sumagot ang isang ahente, sabihin mo ang wika na kailangan mo at iuugnay ka sa isang tagasalin ng wika.

Tiếng Việt (Vietnamese) Thông báo này có Thông tin Quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị thông qua Thị trường Bảo hiểm Sức khỏe (Health Insurance Marketplace®). Tìm xem các ngày quan trọng trong thông báo này. Quý vị có thể cần phải hành động theo một số thời hạn nhất định để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ về phần chi phí. Quý vị có quyền nhận thông tin này và được giúp đỡ bằng ngôn ngữ của quý vị miễn phí. Hãy gọi 1-800-318-2596 và đợi đến khi mở cửa. Khi người đại diện trả lời, hãy nói với họ ngôn ngữ mà quý vị cần sử dụng và quý vị sẽ được kết nối với một thông dịch viên.

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