Form Approved
OMB No. 0938-1213
Appeal Request Form – Employer

Instructions to help you complete the Employer Appeal Request

Use the right form to request an appeal

If you received a Marketplace notice stating that you may be subject to the Employer Shared Responsibility Payment, you can request an appeal by submitting this form or mailing in a letter that includes the information requested on this form.

Use this form if you're appealing a notice you received from:

- The federally-facilitated Health Insurance Marketplace
- A state-based Marketplace operating in:

California	Maryland	Rhode Island
Colorado	Massachusetts	Vermont
District of Columbia	New York	

This appeal may determine if an employee was eligible for help with the costs of coverage through the Marketplace at the same time that you may have offered them affordable health coverage that met the minimum value standard. **This appeal will NOT determine if your organization has to pay the Employer Shared Responsibility Payment.** Only the Internal Revenue Service (IRS), not the Health Insurance Marketplace or the Marketplace Appeals Center, can determine which employers are subject to the Employer Shared Responsibility Payment as stated under section 4980H of the Internal Revenue Code.

IMPORTANT: For 2015, the Employer Shared Responsibility Payment will generally apply to employers with 100 or more full-time equivalent (FTE) employees, and may apply to certain employers with 50 or more FTE employees. **Starting in 2016**, the Employer Shared Responsibility Payment will apply to employers with 50 or more FTE employees.

- If you want to appeal a Small Business Health Options Program (SHOP) eligibility decision, visit **HealthCare.gov/small-businesses/provide-shop-coverage/appeal-a-shop-decision/** for more information.

Timeframe to request an appeal

You must submit your appeal request form **within 90 days** of the date of your Marketplace notice.

Designating a secondary contact

You may authorize a secondary contact to help with your appeal. The secondary contact may act on your behalf, talk with the Marketplace Appeals Center, view your case file, and receive all correspondence regarding your appeal. To authorize a secondary contact complete **Section 2: Designate a secondary contact.**

How to submit this appeal request form

Submit one appeal request per employee listed on the notice you received from the Marketplace.

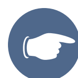
Enter your information directly, then print your completed form. Or, print a blank form to fill in by hand using black or dark blue ink.

Sign the completed form and mail to:

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

You may also fax the form to a secure fax line: **1-877-369-0131**.

You'll receive all future correspondence about this appeal from the Marketplace Appeals Center. The Marketplace Appeals Center is different from the Health Insurance Marketplace.



What happens next?

1. We'll send you a notice letting you know that that we received your appeal request. If there's a problem with the appeal request, we'll tell you how to correct the issue. We'll also send a notice to the employee listed on the notice you received from the Marketplace.
2. We'll review your appeal request, including any documentation provided by you and/or the associated employee. If there's a problem, like if it's missing information or we need clarification, we'll tell you what's missing and how you can provide additional information.
3. We'll send appeal decision notices explaining the outcome of our review to you and to the associated employee.

Additional help

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.

Accessibility
To request this form in an alternate format like Braille, large print, data CD, audio CD, or to request a qualified reader, you can call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676. You can also make a request by sending a fax to 1-844-530-3676, an email to **AltFormatRequest@cms.hhs.gov**, or a letter to Offices of Hearings and Inquiries (OHI), Attn: CMS Alternate Format Team, 7500 Security Boulevard, Mail Stop S1-13-25, Baltimore, MD 21244-1850. Accommodations are available and provided at no cost to you.

To submit your appeal request, see "How to submit this appeal request form" on page 1 of these instructions. If you send your appeal request to the Alternate Format Team address above, your appeal processing may be delayed.

Questions

If your state isn't listed above, or to learn more about your appeal, call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET); and Saturday, 10 a.m. to 5:30 p.m. ET.

Paperwork Reduction Act Disclosure Statement
According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1213. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclaimer** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Marketplace Appeals Center.**

Privacy and 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.

Health Insurance Marketplace

Employer Appeal Request Form

Form Approved
OMB No. 0938-1213
Appeal Request Form – Employer

Use this form to appeal a Marketplace determination that an employee was eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable) in part because your business didn't offer health coverage that met minimum value requirements and was affordable with respect to this employee.

Enter your information directly, then print and sign your completed form. Or, print a blank form to fill in using black or dark blue ink. Use capital letters.

SECTION 1: Tell us about the employer who's requesting this appeal.

1. Business Name

Federal Employer ID Number (EIN) -

Business phone number ( ) -

Primary business mailing address

Suite #

City

State

ZIP code

Name of the primary contact (First name)

(Middle Name)

(Last name)

Primary contact phone number ( ) -

Primary contact mailing address

Suite #

City

State

ZIP code

Title of primary contact

SECTION 2: Designate a secondary contact. (optional)

This is someone who may act on your organization's behalf regarding this appeal request.

Name of the secondary contact (First name)

(Middle Name)

(Last name)

Secondary contact phone number ( ) -

Organization name (if applicable)

Title of secondary contact

Secondary contact mailing address

Suite #

City

State

ZIP code

SECTION 3: Tell us why you're appealing the Marketplace determination of this employee's eligibility for help with the costs of Marketplace coverage.

What's the date on the Marketplace notice? (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

What's the employee's first and last name?

What's the employee's date of birth (if available)? (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

What's the employee's Application ID # (if available on your notice)?

An individual may qualify for help with the costs of Marketplace coverage if the coverage that's offered by an employer doesn't meet minimum value requirements or isn't affordable with respect to the employee.

Use the space below to explain why this employee shouldn't have been eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable). Use extra paper, if necessary. If you're including documents to support your request, send us copies. Keep all original documents.

SECTION 4: Signature

By completing, signing, and dating below, I authorize the Marketplace Appeals Center to perform a review of whether the employer named on this form offered minimum essential coverage through an employer-sponsored plan that's considered affordable with respect to the relevant employee, and meets the minimum value standard.

I understand I may request a copy of my Marketplace appeal record and that certain information about the relevant employee's eligibility determination may or may not be made available to me as described in 45 CFR §155.555(g)(2) and 45 CFR §155.555(h).

By signing this form under penalty of perjury, I declare that I've provided true answers to all the questions that 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

1. Printed name of primary contact (First name, Middle name, Last name)

Title

Signature

Date (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __