SHOP Marketplace
Health Insurance for Small Businesses

03/2018

Form Approved
OMB No. 0938-1213

Instructions to help you complete the SHOP Employee Eligibility Appeal Request

Use the right form to request an appeal

- This form is for employees of businesses that participate in the Small Business Health Options Program (SHOP) Marketplace.
- If you applied for your employer's SHOP Marketplace coverage and were denied, you can request an appeal.
- Some states operate their own SHOP. If you're not sure this form is the right one for you, visit **HealthCare.gov/small-businesses/** to learn more about your state's SHOP.
- Visit **HealthCare.gov/marketplace-appeals** to learn more about Marketplace appeals.

Timeframe to request an appeal

We must receive your appeal request **within 90 days** of the date on the SHOP eligibility determination notice that you're appealing.

How to submit this form

Complete and sign this form, and mail it with copies of any supporting documents to:

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

Or, fax the form and documents to a secure fax line: 1-877-369-0131.

Keep a copy of all forms for your records.

How to submit additional information

You may submit additional information along with this Appeal Request Form to support your appeal. Send copies only. Keep all original documents. We'll consider all timely information when making a final determination. Submit all available information when you send this Appeal Request Form.

What happens next?

1. **We'll contact you.** We'll send a notice to let you know that we got your appeal request. It will explain the appeal process, and give you instructions for sending additional information, if needed. You'll have 15 days from the date of this notice to send any additional information if it's required. If there's a problem with your appeal request, like if it's missing information, we'll tell you how to correct the issue. We'll also tell your employer about your appeal request. Your employer can submit information to support your appeal.
2. **We'll review your information.** Your appeal request will be reviewed along with the information used by the SHOP Marketplace to determine your eligibility.
3. **We'll send a decision about your appeal.** A final decision will be mailed to you and your employer within 90 days of when we get your appeal request.

Additional help

Language assistance services
If you need help in a language other than English, you have the right to get help and information in your language at no cost. Call the SHOP Call Center at 1-800-706-7893. TTY users should call 711 to reach a call center representative. Hours of operation are Monday through Friday, 9 a.m. to 5 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 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, 10:00 a.m. to 5:30 p.m. ET. You can also make a request in writing by fax (1-877-360-0130) or mail (Marketplace Appeals Center, P.O. Box 311, Pittston, PA 18640). Accommodations are provided at no cost to you.

To submit your appeal request, see "How to submit this form" on page 1 of these instructions.

Choose an authorized representative

You have the right to choose an authorized representative to help you with your appeal.

This is a trusted person who has your permission to talk with us about your appeal, see your information, and act for you on matters related to your appeal, including getting information about you and signing your appeal request on your behalf.

To appoint an authorized representative, complete and mail the form "Appoint an authorized representative for my appeal," available at **HealthCare.gov/marketplace-appeals/getting-help**. You can also call the Marketplace Appeals Center to request this form. Even if you already completed an authorized representative form for your Marketplace application, you need to complete an additional form for your appeal.

Questions

For more information, visit **HealthCare.gov/small-businesses/**, or call the SHOP Call Center at 1-800-706-7893. TTY users should call 711. Hours of operation are Monday through Friday, 9 a.m. to 5 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.

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SHOP Appeal Request Form – Employee

SHOP Employee Eligibility Appeal Request

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 and fill in the circles (◯) like this → ●.

SECTION 1: Employee information.

This should be filled out by the person requesting the appeal, or by an authorized representative.

1. Name of person who was denied SHOP coverage (First name)

(Middle Name)

(Last name)

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

Employee's street address

Apartment or suite number

City

State

ZIP code

Daytime phone number

( ) -

Email address (optional)

2. Employer

Employer's mailing address

Apartment or suite number

City

State

ZIP code

Employer's phone number

( ) -

Employer ID Number (EIN) (optional) This can be found on your W-2 form.

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SECTION 2: Reason for this appeal.

Your eligibility determination notice explains if you're eligible for SHOP coverage offered by your employer. You can appeal the eligibility determination for either of these reasons:

- You weren't eligible to enroll.
- You think that the SHOP didn't provide your eligibility determination in a timely manner.

If your employer wasn't eligible to participate in the SHOP, you can't appeal that decision, but your employer can.

Tell us when you enrolled or tried to enroll in SHOP coverage offered by your employer.

○ During Open Enrollment ○ During a Special Enrollment Period

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

		/		/				

Date your employer chose for SHOP coverage to start (mm/dd/yyyy)

		/		/				

Date your employer's SHOP coverage would end (mm/dd/yyyy)

		/		/				

Explain the reason for your appeal. Your explanation should include the reason you think we made a mistake. Add more pages if needed. If you're including documents to support your request, send us copies. Keep all original documents.

SECTION 3: Signature

This information applies for all individuals signing below who are 18 or older.

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

Printed name of person requesting an appeal (or authorized representative, if applicable) (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

		/		/				