Health Insurance Marketplace

OMB Exempt

Marketplace Appeal Record Request Form

- Complete the form by telling us whose appeal record you are requesting and where we should send the record.
- Have all the tax filers on the Health Insurance Marketplace® application sign the form.
- Mail or fax the signed form to the Marketplace Appeals Center.

STEP 1 Whose appeal record is being requested?

Enter information about the person who's appealing a Marketplace determination (also called the "appellant").

First name:

Last name:

Date of birth (mm/dd/yyyy):

Appeal Case ID # (if you have one):

APL-

STEP 2 Where should the appeal record be mailed?

Tell us where to mail the appeal record for the person you listed in Step 1. **Make sure you enter a street address.** We can't send appeal records to a P.O. Box.

First name:

Last name:

Date of birth (mm/dd/yyyy):

Street address

Apartment or suite number

City

State

Zip code

Relationship to the person in Section 1.

- ☐ Self
- ☐ Authorized Representative designated by this person and confirmed by the Marketplace
- ☐ Power of Attorney with authority to receive this person's appeal record
- ☐ Legal Guardian with authority to receive this person's appeal record

Important: Any recordings in your appeal record will be sent to you in an audio format. If you require a different format, please let us know below.

- ☐ I don't require a different format
- ☐ I need recordings to be sent to me in the following format:

STEP 3 Signatures

Have all the tax filers age 18 and older listed on your Marketplace application sign the form.

For all tax filers in the household: Your approval to let the Marketplace share Social Security Administration and federal tax information for use in releasing your appeal record.

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 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, with an authorized representative or other individuals without your consent. Sign below to give your consent.

I understand that by completing, signing, and dating below, I authorize the Marketplace to disclose to the individuals whose signatures are provided below, as well as to any authorized representative, any federal tax information in my eligibility record which was provided by the Internal Revenue Service. I also give my consent to the Marketplace to release 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. The information in my eligibility record was collected based on the application I filled out (or was completed for me) or an application 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.

Each tax filer 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 I give my written notification that I want all or any of the 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 question, and I've answered them 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 a knowing and willful request for, or acquisition of, records about an individual under false pretense is a criminal offense under the Privacy Act (45 CFR 5b.5(b)(2)(ii)), and that I may be subject to a $5,000 fine. I also may violate additional laws and be subject to other penalties.

Signature

I certify that I am the appellant whose records are being requested. Or, I'm the Authorized Representative, have legal Power of Attorney, or legal guardianship as indicated in Section 2.

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

Signature

Date (mm/dd/yyyy)

Signatures of each person who's a tax filer in your household

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

Signature

Date (mm/dd/yyyy)

3. **Printed name (First name, Middle name, Last name)**

Signature

Date (mm/dd/yyyy)

4. **Printed name (First name, Middle name, Last name)**

Signature

Date (mm/dd/yyyy)

5. **Printed name (First name, Middle name, Last name)**

Signature

Date (mm/dd/yyyy)

6. **Printed name (First name, Middle name, Last name)**

Signature

Date (mm/dd/yyyy)

7. **Printed name (First name, Middle name, Last name)**

Signature

Date (mm/dd/yyyy)

8. **Printed name (First name, Middle name, Last name)**

Signature

Date (mm/dd/yyyy)

STEP 4 Submit your form

Send your signed form to the Marketplace Appeals Center.

Send your completed and signed form:

- **By Mail:** Marketplace Appeals Center
  PO Box 311
  Pittston PA 18640

- **By Secure Fax:** 1-877-369-0129

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).

Accessibility
You have the right to get Marketplace information in an accessible format, like large print, Braille, or audio. Call the Marketplace Appeals Center at 1-855-231-1751 for more information. TTY users can call 711.

Language Assistance
If you need help in a language other than English, call 1-855-231-1751 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users can call 711.

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 (including sexual orientation and gender identity), 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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