Health Insurance Marketplace

Marketplace Eligibility Appeal Request

- **Submit this form within 90 days of the date on the Marketplace Eligibility Notice you're appealing.**
- Include any documents you have to help your appeal (Step 6).
- Have the tax filer on the Marketplace application sign the form (Step 7).

Person filling out this form:

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

STEP 1 Whose eligibility is being appealed?

Include ONLY the people on your Marketplace application whose eligibility is being appealed.

Person 1 appealing

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

* **Date of birth:** * **Email:**

* **Daytime phone number:**

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

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

Person 2 appealing

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

Date of birth: **Email:**

Person 3 appealing

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

Date of birth: **Email:**

Person 4 appealing

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

Date of birth: **Email:**

STEP 2 Reason for the appeal

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

Notice Date (mm/dd/yyyy):

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

- ☐ The Marketplace said I'm not eligible to buy a Marketplace plan.
- ☐ The Marketplace said I'm not eligible for financial help with Marketplace costs (including premium tax credits or cost-sharing reductions).
- ☐ I disagree with the amount of financial help the Marketplace said I qualify for.
- ☐ The Marketplace said I'm not eligible for a Special Enrollment Period to enroll in or change my Marketplace plan.
- ☐ The Marketplace said I'm not eligible for a Catastrophic plan.
- ☐ The Marketplace said I'm 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 filing this appeal more than 90 days after the date on the Marketplace Eligibility Notice you're appealing, please also explain the delay in filing your 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.)

- ☐ **No, I don't need to expedite my appeal.**
- ☐ **Yes, I need to expedite my appeal.** Please explain the reason you need an expedited appeal.

STEP 4 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 5 You have the right to appoint a representative (optional)

You have the right to choose an authorized representative to help with your appeal. This person can be a friend, family member, or someone else you trust. Your authorized representative will act for you on all matters related to your appeal. **All communications about your appeal (including email and text reminders) will go to your authorized representative, not you.**

☐ **No, I'm not appointing an authorized representative. Go to Step 6.**

☐ **Yes, I'm appointing an authorized representative to help with my appeal.** Please fill out the section below. If you change your mind, you must call or write the Marketplace Appeals Center to remove your authorized representative.

Authorized Representative's First name: **Last name:**

Date of birth: **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):**

STEP 6 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.

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. **Requesting your transcript online is faster.**

STEP 7 Signature of the tax filer listed 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.

Signature of the tax filer listed on your Marketplace application

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

Signature **Today's 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.

STEP 8 Next Steps

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

We'll send you a notice letting you know we got your appeal request and giving more information about the appeal process within 10-15 days.