Health Insurance Marketplace

Instructions to help you complete the Employer Appeal Request

11/2018
Form Approved
Appeal Request Form – Employer

Use this 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	District of Columbia	New York
Colorado	Maryland	Rhode Island
Connecticut	Massachusetts	Vermont

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: Effective 2016, the Employer Shared Responsibility Payment applies to employers with 50 or more full-time 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 **Step 2: Designate a secondary contact.**

How to submit this 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 together with any supporting documents to:

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

you may also fax the form and documents 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 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, including all 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 the associated employee.

Additional help

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 1-855-739-2231. 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 (1-877-360-0130) 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.

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 can call 1-855-739-2231. Hours of operations are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET).

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

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 that was affordable with respect to this employee.
Enter your information directly, then print and sign your completed form. Or, print a blank form and fill in using black or dark blue ink. Use capital letters.

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

Enter your information directly, then print and sign your completed form.

1. Organization Name

Federal Employer ID Number (EIN) **Organization Phone Number**

Organization's Primary Mailing Address **Suite #**

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

Primary Contact First Name **Middle Name**

Last Name **Primary Contact phone number**

Title of Primary Contact

Organization of Primary Contact (if different than organization listed above)

Primary Contact mailing address **Suite #**

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

STEP 2: Designate a secondary contact.

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

Secondary Contact First Name **Middle Name**

Last Name **Secondary Contact phone number**

Title of Secondary Contact **Organization of Secondary Contact (if applicable)**

Secondary Contact mailing address **Suite #**

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

STEP 3: 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. Print name of primary contact First Name, Middle Name, Last Name

Title

Signature

Date (mm/dd/yyyy)

STEP 4: 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 Application ID # (if available on your notice)?

What's the employee's first name?

What's the employee's last name?

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

/ /

What's the employee's address (if available)?

Mailing Address:

City

State

ZIP code

From which exchange did you receive the Marketplace notice?

- ◯ **The federally-facilitated Health Insurance Marketplace**
- ◯ **Access Health CT**
- ◯ **Connect for Health Colorado**
- ◯ **Covered California**
- ◯ **DC Health Link**
- ◯ **Health Source Rhode Island**
- ◯ **Maryland Health Connection**
- ◯ **Massachusetts Health Connector**
- ◯ **New York State of Health**
- ◯ **Vermont Health Connect**

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

Select your reason for appeal and then 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. Please send a copy of the Marketplace notice that identifies this employee when you submit your appeal request. If you're including documents to support your request, send us copies. Keep all original documents.

- ◯ **This employee was enrolled in employer-sponsored coverage.**
- ◯ **This employee was offered affordable employer-sponsored coverage which met the minimum value standard.**
- ◯ **This employee was eligible for affordable employer-sponsored covered that met the minimum value standard after the end of a waiting period. (Note: You will need to show when the employee was offered employer-sponsored coverage and when the waiting period ended.)**

Note: The following reasons for appeal fall outside of the jurisdiction of the Marketplace Appeals Center:

- The employee listed on the Marketplace notice has not worked for your company this year.
- The employee listed on the Marketplace notice is not a full-time employee.
- The employee listed on the Marketplace notice is not your company's employee.
- Your company does not employ at least 50 employees.

STEP 4: (continued)

Explain why this employee shouldn't have been eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable). Please send a copy of the Marketplace notice that identifies this employee when you submit your appeal request. If you're including documents to support your request, send us copies. Keep all original documents.

To view the acceptable documentation please refer to the Employer Document Guide at **cms.gov/CCIIO/Programs-and-Initiatives/Employer-Initiatives/Employer-Initiatives.html**. Please submit a copy of the necessary documentation for each unique employee appeal.