APPEAL REQUEST FOR DC HEALTH LINK SMALL BUSINESS MARKETPLACE EMPLOYEES

To appeal a determination that I am ineligible for coverage through DC Health Link, please complete this form.

**EMPLOYEE NAME (Appellant):** ________________________________

**DATE:** _______________  **TELEPHONE #:** ____________________________

**ADDRESS:** _______________________________________________________

**NAME OF EMPLOYER:** _____________________________________________

**EMPLOYER POINT OF CONTACT:**

**NAME:** __________________________________________________________

**ADDRESS:** _______________________________________________________

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**Section - 1**  
I am requesting a hearing because (check all that apply)

<table>
<thead>
<tr>
<th></th>
<th><strong>Health Benefit Exchange Authority – Small Business Marketplace</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>I applied for coverage through my employer on the DC Health Link Small Business Marketplace and have been determined ineligible.</td>
</tr>
<tr>
<td>b)</td>
<td>I applied for coverage through my employer on the DC Health Link Small Business Marketplace and did not receive a timely eligibility determination.</td>
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<tr>
<td>c)</td>
<td>I applied for coverage through my employer on the DC Health Link Small Business Marketplace and did not receive notice of my eligibility determination.</td>
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</tbody>
</table>
Section 2 - Explain the reason for your appeal. Your explanation should include the reason why you believe the DC Health Benefit Exchange Authority made a mistake. You can attach additional pages if necessary.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Section 3 – Special Needs (OPTIONAL) - Check any special services that you would need to help you participate in the hearing:

☐ I need an interpreter
  ☐ What Language? _________________________

☐ I need to participate in the hearing by telephone for the following good reason(s). _________________________
  _________________________
  _________________________

  ☐ What telephone number should we call to contact you for the hearing? _________________________

☐ I need a reasonable accommodation at the hearing.
  ☐ What type of service do you need? _________________________

EMERGENCY/EXPEDITED REQUEST

☐ Check here if your life, health, or ability to attain, maintain, or regain maximum function is currently in jeopardy because you have an immediate need for health services. If so, you must attach documentation (such as a doctor’s note) explaining the immediate need. Failure to do so will result in your appeal being handled on a standard schedule.

Section 4 – Contact Information

Attorney/Representative (if any): Person preparing request (if other than applicant):

Name: ___________________________ Print name: ___________________________
Address: ___________________________ Office/Center: ___________________________
City, State, Zip: ___________________________ Telephone #: ___________________________
Telephone #: ___________________________

I’m signing this appeal request 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 the submission of a false statement on this form is a crime punishable under D.C. Official Code § 22-2405.

Signature: ___________________________ Date: ___________________________

SEND BY U.S. MAIL, E-MAIL, OR FAX TO:

DC Health Benefit Exchange Authority
ATTN: Eligibility Appeals Team (SHOP)
1225 Eye Street, NW, 4th Floor
Washington, DC 20005

E-MAIL: SHOP.Appeals@dc.gov
FAX: (202) 724-2041
PHONE: (855) 532-5465