OAH Case No. _____
(Official Use Only)

DC HEALTH LINK
Get the facts. Get covered.

Appeal Request For DC Health Link Small Business Marketplace Employees

To appeal a determination that you are ineligible to enroll in coverage through DC Health Link, please complete this form

---

Employee Name (Appellant): _____ **Date:** ____/____/____

Telephone Number: (____) ____ - _____

Address

_____

_____

City: _____ State: _____ Zip: _____

Mailing Address (If Different)

_____

_____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Employer Point of Contact:

Name: _____

Address

_____

_____

City: _____ State: _____ Zip: _____

Mailing Address (If Different)

_____

_____

City: _____ State: _____ Zip: _____

Section 1 – I am requesting a hearing because: (check all that apply)

DC Health Benefit Exchange Authority - Small Business Marketplace

a) ☐ I applied for coverage through my employer on the DC Health Link Small Business Marketplace and have been determined ineligible.

b) ☐ I applied for coverage through my employer on the DC Health Link Small Business Marketplace and did not receive a timely eligibility determination.

c) ☐ I applied for coverage through my employer on the DC Health Link Small Business Marketplace and did not receive notice of my eligibility determination.

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. 500 character limit in pdf.

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). 300 character limit.

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):

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Telephone Number: ( ) -

Person preparing request (if other than applicant):

Name: _____

Office/Center: _____

Telephone Number: ( ) -

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, or E-MAIL 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

PHONE: (855) 532-5465