OAH Case No. _____
(Official Use Only)

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 #:** _____

		Mailing Address (If Different)
ADDRESS:	_____	_____
	_____	_____
	_____	_____

NAME OF EMPLOYER: _____

EMPLOYER POINT OF CONTACT:

NAME: _____

		Mailing Address (If Different)
ADDRESS:	_____	_____
	_____	_____
	_____	_____

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

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.

(TURN SHEET OVER)

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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):

Name: _____
Address: _____
_____
City, State, Zip:_____
Telephone #: _____

Person preparing request (if other than applicant):

Print name: _____
Office/Center: _____
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

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