APPEAL REQUEST FOR DC HEALTH LINK SMALL BUSINESS MARKETPLACE

EMPLOYERS

To appeal a determination that your business/organization is ineligible to offer coverage through DC Health Link, please complete this form.

EMPLOYER NAME (Appellant): ________________________________________________

DATE: ________________

EMPLOYER PRIMARY CONTACT NAME: _____________________________________

TELEPHONE #: ______________________________________________

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 to offer coverage through the DC Health Link Small Business Marketplace and have been determined ineligible.

b) ___ I applied to offer coverage through the DC Health Link Small Business Marketplace and did not receive a timely eligibility determination.

c) ___ I applied for coverage through 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.

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

Version Date: 7/12/17
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  E-MAIL: SHOP.Appeals@dc.gov
ATTN: Eligibility Appeals Team (SHOP)  FAX: (202) 724-2041
1225 Eye Street, NW  PHONE: (855) 532-5465
4th Floor
Washington, DC 20005