Form Approved
OMB No. 0938-1213
SHOP Appeal Request Form – Employer

Instructions to help you complete the SHOP Employer Eligibility Appeal Request

Use the right form to request an appeal

- This form is for employers that applied to participate in the Small Business Health Options Program (SHOP) Marketplace.
- If you were denied eligibility to participate as an employer in the federally-facilitated SHOP Marketplace, you can request an appeal.
- If your business isn't eligible to participate in SHOP, you can re-apply on a monthly basis.
- Some states operate their own SHOP. If you're not sure this form is the right one for you, visit **HealthCare.gov/small-businesses/** to learn more about your state's SHOP.
- Visit **HealthCare.gov/marketplace-appeals** to learn more about Marketplace appeals.

Timeframe to request an appeal

We must receive your appeal request **within 90 days** of the date on the SHOP eligibility determination notice that you're appealing.

How to submit this form

Complete and sign this form, and mail it with copies of any supporting documents to:

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

Or, fax the form and documents to a secure fax line: 1-877-369-0131.

Keep a copy of all forms for your records.

How to submit additional information

You may submit additional information along with this Appeal Request Form to support your appeal. Send copies only. Keep all original documents. We'll consider all timely information when making a final determination. Submit all available information when you send this Appeal Request Form.

What happens next?

1. **We'll contact you.** We'll send a notice to let you know that we got your appeal request. It will explain the appeal process, and give you instructions for sending additional information, if needed. You'll have 15 days from the date of this notice to send any additional information if it's required. If there's a problem with your appeal request, like if it's missing information, we'll tell you how to correct the issue. We'll also tell your employer about your appeal request. Your employer can submit information to support your appeal.
2. **We'll review your information.** Your appeal request will be reviewed along with the information used by the SHOP Marketplace to determine your eligibility.
3. **We'll send a decision about your appeal.** A final decision will be mailed to you within 90 days when we get your appeal request.

Additional help

Language assistance services

If you need help requesting an appeal in a language other than English, you have the right to get help and 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); and Saturday, 10:00 a.m. to 5:30 p.m. 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

For more information, visit **HealthCare.gov/small-businesses/**.

Paperwork Reduction Act Disclosure Statement

According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1213. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclaimer** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Marketplace Appeals Center.**

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.

SHOP Marketplace
Health Insurance for Small Businesses

Form Approved
OMB No. 0938-1213
SHOP Appeal Request Form – Employer

SHOP Employer Eligibility Appeal Request

Enter your information directly, then print and sign your completed form.
Or, print a blank form to fill in using black or dark blue ink.

SECTION 1: Employer information.

Your SHOP Application ID number

__ __ - __ __ __ __ __ __ __

EMPLOYER CONTACT

This should be filled out by the person requesting the appeal. The Marketplace will correspond with this person regarding this appeal. There's also space for identifying a secondary contact for the employer.

1. Name of the primary contact on your SHOP application (First name)

(Middle name)

(Last name)

What's the earliest effective date you chose for your group? (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Primary contact's title

Business name

Business mailing address

Apartment or suite number

City

State

ZIP code

Primary contact's phone number

(__ __ __) __ __ __ - __ __ __ __

Email address (optional)

Employer ID Number (EIN)

__ __ - __ __ __ __ __ __ __

SECONDARY CONTACT

(additional person who may act on your behalf regarding this appeal request)

1. Name (First name)

(Middle Name)

(Last name)

Secondary contact's title

Secondary contact's business mailing address

Apartment or suite number

City

State

ZIP code

Secondary contact's phone number

( ) -

Email address (optional)

SECTION 2: Reason for this appeal.

Your eligibility determination notice explains if you qualify for participation in the SHOP Marketplace as an employer. You can appeal the eligibility determination for either of these reasons:

- You weren't eligible.
- You think that the SHOP didn't make your eligibility determination in a timely manner.

Date of eligibility notice (mm/dd/yyyy)

/ /

Explain the reason for your appeal. Your explanation should include the reason you think we made a mistake. Add more pages if needed. If you're including documents to support your request, send us copies. Keep all original documents.

SECTION 3: Signature

I'm signing this form 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 I may be subject to penalties under federal law if I provide false and/or untrue information.

Printed name of person requesting an appeal (or authorized representative, if applicable) (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

/ /