Instructions to help you complete the Request for Appeal Record form

Form Approved
OMB No. 0938-1213

How to submit this request for an appeal record

Mail the completed form to:

Marketplace Appeals Center
P.O. Box 311
Pittston, PA 18640

You may also fax the form to a secure fax line: **1-877-369-0129**.

Additional help

Language assistance services
If you need language assistance in a language other than English, you have the right to get help and information in your language at no cost. Call the Marketplace Call Center at 1-800-318-2596.

Accessibility
To request this form in an alternate format like Braille, large print, data CD, audio CD, or to request a qualified reader, you can call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676. You can also make a request by sending a fax to 1-844-530-3676, an email to **AltFormatRequest@cms.hhs.gov**, or a letter to Offices of Hearings and Inquiries (OHI), Attn: CMS Alternate Format Team, 7500 Security Boulevard, Mail Stop S1-13-25, Baltimore, MD 21244-1850. Accommodations are available and provided at no cost to you.

To send your request for an appeal record, see "How to submit this request" above. If you send it to the Alternate Format Team address, you may have a delay in processing your request for an appeal record.

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.

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.**

Request for Appeal Record

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REQUEST FOR APPEAL RECORD

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. Use capital letters and fill in the circles (◯) like this → ●.

NOTE: all tax filers in the household must sign this form.

SECTION 1: Enter information for the person who's appealing a Marketplace decision (also called the "appellant").

First name

Middle name

Last name

Date of birth (mm/dd/yyyy)

Appeal Case ID # (if you have one)

APL-

SECTION 2: Tell us where to mail the appeal record for the person in Section 1.

NOTE: Enter a street address only. We can't send the appeal record to a P.O. box.

First name

Middle name

Last name

Date of birth (mm/dd/yyyy)

Street address

Apartment or suite number

City

State

ZIP code

Relationship to the person in Section 1.

- ◯ Self
- ◯ Authorized Representative designated by this person and confirmed by the Marketplace
- ◯ Power of Attorney with authority to receive this person's appeal record
- ◯ Legal Guardian with authority to receive this person's appeal record.

SECTION 3: Signatures

For all tax filers in the household: Your approval to let the Marketplace share Social Security Administration and federal tax information for use in releasing your appeal record

We may need to share with you or your authorized representative the information the Marketplace used to determine your eligibility. This information might include employment income information from a consumer reporting agency, information about income you receive from the Social Security Administration, and federal tax information from the Internal Revenue Service about members of your household, including information from your last filed income tax return. The Marketplace can't share federal income tax information, or monthly and annual Social Security Benefit information under Title II of the Social Security Act from the Social Security Administration, with an authorized representative or other individuals without your consent. Sign below to give your consent.

I understand that by completing, signing, and dating below, I authorize the Marketplace to disclose to the individuals whose signatures are provided below, as well as to any authorized representative, any federal tax information in my eligibility record which was provided by the Internal Revenue Service. I also give my consent to the Marketplace to release my monthly and annual Social Security Benefit information under Title II of the Social Security Act to these same individuals, along with other information in my Marketplace eligibility record. The information in my eligibility record was collected based on the application I filled out (or was completed for me) or an application that listed me as a household member, and from other data sources like income and employment verification from a consumer reporting agency that were used to make the Marketplace eligibility determination.

Each tax filer of the household must consent to the disclosure of his or her own federal tax information, and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below. The authorization is valid until I give my written notification that I want all or any of the authorized representatives removed from this appeal.

I'm signing this form under penalty of perjury, which means I've provided true answers to all the question, and I've answered them to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

I understand that a knowing and willful request for, or acquisition of, records about an individual under false pretense is a criminal offense under the Privacy Act (45 CFR 5b.5(b)(2)(ii)), and that I may be subject to a $5,000 fine. I also may violate additional laws and be subject to other penalties.

Signature

I certify that I am the appellant whose records are being requested. Or, I'm the Authorized Representative, have legal Power of Attorney, or legal guardianship as indicated in Section 2.

1. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy) / /

Signatures of each person who's a tax filer in your household

2. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy) / /

3. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy) / /

4. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy) / /

Signatures of each person who's a tax filer in your household *(Continued)*

5. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

6. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

7. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

8. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)