SHOP Marketplace
Health Insurance for Small Businesses

04/2016

Form Approved
OMB No. 0938-1213

Instructions to help you complete the SHOP Employer Eligibility Appeal Request Form

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

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.
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 within 90 days of when we get your appeal request.

Additional help

Language assistance services
If you need help in a language other than English, you have the right to get help and information in your language at no cost. Call the SHOP Call Center at 1-800-706-7893. TTY users should call 711 to reach a call center representative. Hours of operation are Monday through Friday, 9 a.m. to 7 p.m. Eastern Time (ET).

Accessibility
To request an auxiliary aid or service, you can:

- Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676.
- Send a fax to 1-844-530-3676.
- Send an email to: **AltFormatRequest@cms.hhs.gov**
- Use this address only to send a letter requesting an auxiliary aid or service:
  Centers for Medicare and Medicaid Services
  Office of Equal Employment Opportunity & Civil Rights (OEOCR)
  Attn: CMS Alternate Format Team
  7500 Security Boulevard, Mail stop: N2-22-16
  Baltimore, MD 21244-1850

To submit your appeal request, see **How to submit this form** on page 1 of these instructions. Don't use **Accessibility** contact information to submit an appeal request.

Questions

For more information, visit **HealthCare.gov/small-businesses/**, or call the SHOP Call Center at 1-800-706-7893. TTY users should call 711. Hours of operation are Monday through Friday, 9 a.m. to 7 p.m. ET.

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/**.

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.

SHOP Employer Eligibility Appeal Request Form

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SHOP Appeal Request Form – Employer

Please print in capital letters using black or dark blue ink only.
Fill in the circles (◯) like this → ●.

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)

__ __ / __ __ / __ __ __ __

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)

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

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 (located on the upper right corner of the 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.

Signature of person requesting an appeal (or secondary contact, if applicable)

Date (mm/dd/yyyy)

__ / __ / ____

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