Form Approved
OMB No. 0938-1213

Instructions to help you complete the Employer Appeal Request Form

Using this form

- If you received a Marketplace notice stating that you may be subject to the Employer Shared Responsibility Payment, you can request an appeal by submitting this form or mailing in a letter that includes the information requested on this form.

  Use this form if you're appealing a notice you received from:
  - The federally-facilitated Health Insurance Marketplace
  - A state-based Marketplace operating in:

    California
    Colorado
    District of Columbia
    Kentucky
    Maryland
    Massachusetts
    New York
    Vermont

  This appeal may determine if an employee was eligible for help with the costs of coverage through the Marketplace at the same time that you may have offered them affordable health coverage that met the minimum value standard. **This appeal will NOT determine if your organization has to pay the Employer Shared Responsibility Payment.** Only the Internal Revenue Service (IRS), not the Health Insurance Marketplace or the Marketplace Appeals Center, can determine which employers are subject to the Employer Shared Responsibility Payment as stated under section 4980H of the Internal Revenue Code.

  IMPORTANT: For 2015, the Employer Shared Responsibility Payment will generally apply to employers with 100 or more full-time equivalent (FTE) employees, and may apply to certain employers with 50 or more FTE employees. **Starting in 2016**, the Employer Shared Responsibility Payment will apply to employers with 50 or more FTE employees.

- If you want to appeal a Small Business Health Options Program (SHOP) eligibility decision, visit HealthCare.gov/small-businesses/provide-shop-coverage/appeal-a-shop-decision/ for more information.

Timeframe to request an appeal

You must submit your appeal request form **within 90 days** of the date of your Marketplace notice.

Designating a secondary contact

You may authorize a secondary contact to help with your appeal. The secondary contact may act on your behalf, talk with the Marketplace Appeals Center, view your case file, and receive all correspondence regarding your appeal. To authorize a secondary contact complete **Section 2: Designate a secondary contact.**

How to submit this form

Complete and sign this form, and mail it with **copies** of any supporting documents to the address shown below.

Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0061

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

You'll receive all future correspondence about this appeal from the Marketplace Appeals Center. The Marketplace Appeals Center is different from the Health Insurance Marketplace.

What happens next?

1. We'll send you a notice letting you know that that we received your appeal request. If there's a problem with the appeal request, we'll tell you how to correct the issue. We'll also send a notice to the employee listed on the notice you received from the Marketplace.
2. We'll review your appeal including any additional documentation provided by you and/or the associated employee. We may request additional information.
3. We'll send appeal decision notices explaining the outcome of our review to you and to the associated employee.

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 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)
  7500 Security Boulevard, Room N2-22-16
  Baltimore, MD 21244-1850
  Attn: CMS Alternate Format Team

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

Contact the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. Hours of operation are Monday through Friday, 7:30 a.m. to 8:30 p.m. Eastern Time (ET); and Saturday, 10:00 a.m. to 5:30 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.

Employer Appeal Request Form

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Appeal Request Form – Employer

Use this form to appeal a Marketplace determination that an employee was eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable) in part because your business didn't offer health coverage that met minimum value requirements and was affordable with respect to this employee.

Please print in capital letters using black or dark blue ink only.

SECTION 1: Tell us about the employer who's requesting this appeal.

1. Business Name			Federal Employer ID Number (EIN)
			__ - _____
Primary business mailing address			Suite #
City	State	ZIP code	
Name of the primary contact (First name, Middle initial, Last name)			Phone number
			___ - ___ - ____
Title of primary contact			
Primary business mailing address			Suite #
City	State	ZIP code	Phone number
			___ - ___ - ____

SECTION 2: Designate a secondary contact. (optional)

This is someone who may act on your organization's behalf regarding this appeal request.

Name of the secondary contact (First name, Middle initial, Last name)			Phone number
			___ - ___ - ____
Organization name (if applicable)			Title
Secondary contact mailing address			Suite #
City	State	ZIP code	Phone number
			___ - ___ - ____

SECTION 3: Tell us why you're appealing the Marketplace determination of this employee's eligibility for help with the costs of Marketplace coverage.

What's the date on the Marketplace notice? (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

What's the employee's first and last name?

What's the employee's date of birth (if available)?

__ __ / __ __ / __ __ __ __

What's the employee's Application ID # (if available on your notice)?

An individual may qualify for help with the costs of Marketplace coverage if the coverage that's offered by an employer doesn't meet minimum value requirements or isn't affordable with respect to the employee.

Use the space below to explain why this employee shouldn't have been eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable). Use extra paper, if necessary. If you're including documents to support your request, send us copies. Keep all original documents.

SECTION 4: Signature

By completing, signing, and dating below, I authorize the Marketplace Appeals Center to perform a review of whether the employer named on this form offered minimum essential coverage through an employer-sponsored plan that's considered affordable with respect to the relevant employee, and meets the minimum value standard.

I understand I may request a copy of my Marketplace appeal record and that certain information about the relevant employee's eligibility determination may or may not be made available to me as described in 45 CFR §155.555(g)(2) and 45 CFR §155.555(h).

By signing this form under penalty of perjury, I declare that I've provided true answers to all the questions that I've answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

Signature

1. Printed name of primary contact (First name, Middle name, Last name)	Title
Signature	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __