CONNECT for HEALTH COLORADO

ELG-008-01

REQUEST FOR APPEAL

Once you/your authorized representative completes this form, either:

- Upload it to "My Documents" in your Connect for Health Colorado online account, and make sure you tag it as an appeal request using the drop down description of the document.
- Mail it to Office of Conflict Resolution and Appeals, 4600 South Ulster Street, Suite 300 Denver, CO, 80237
- Fax it to Appeals Team at 303-322-4217

You/your authorized representative can also submit your appeals request over the phone at 1-855-PLANS-4-YOU (1-855-752-6749). TTY at 1-855-346-3432.

Disclaimer: Depending on the decision made as a result of your appeal, you may have to repay some or all of the financial assistance you received during the appeal process. In addition, if we determine other people in your household eligible for health insurance through the Marketplace, their eligibility may also change. The Marketplace will let you know of the changes and determine eligibility for you and the members of your household, if applicable.

For C4HCO Staff Only	
Date appellant received eligibility notice:	Date appeal request was received by The Marketplace:

STEP 1: Appellant Information

1. Appellant First name, Middle name, Last name, & Suffix			Marketplace Account ID # (optional)
2. Home Address (leave blank if you do not have one.)			3. Apartment or Suite number
4. City	5. State	6. ZIP Code	7. County
8. Mailing Address (if different from home address)			9. Apartment or Suite number
10. City	11. State	12. Zip Code	13. County

14. Daytime Phone number **( )** - Ext._____	Phone Type: ☐ Cell ☐ Home ☐ Work Prefered phone number: ☐ **Yes** ☐ **No**
15. Evening Phone number **( )** - Ext._____	Phone Type: ☐ Cell ☐ Home ☐ Work Prefered phone number: ☐ **Yes** ☐ **No**
16. Email address	Preferred hours to contact you
17. Name of authorized Representative (if applicable)	
18. Email address of authorized representative (if applicable)	
19. Daytime number of authorized Representative **( )** - Ext._____	Phone Type: ☐ Cell ☐ Home ☐ Work Prefered phone number: ☐ **Yes** ☐ **No**
20. Evening number of authorized Representative **( )** - Ext._____	Phone Type: ☐ Cell ☐ Home ☐ Work Prefered phone number: ☐ **Yes** ☐ **No**
21. Prefered hours to contact authorized Representative (if applicable)	

STEP 2: Appeal Information

Type of appeal (check all boxes that apply):

- ☐ APTC/CSR denied or terminated incorrectly[1]
- ☐ The amount of APTC or CSR amount determined is incorrect[1]
- ☐ Medicaid/CHP+denied or terminated incorrectly
- ☐ People included in my household is wrong
- ☐ The amount or type of income that was used to determine my eligibility is wrong
- ☐ Denied or incorrectly terminated for coverage under the Colorado Young Adult Plan
- ☐ Denied or incorrectly terminated for coverage under the Small Business Marketplace
- ☐ Other: Please explain: _____

_____

_____

What determination are you appealing? (OPTIONAL)

By filling out this section, you are taking advantage of your right to appeal the decisions made by either the Connect for Health Colorado Marketplace or the Department of Health Care Policy and Financing or both. Completing this form will help in the timely processing of your appeal request. By checking the "Only the Advance Premium Tax Credit and Cost Sharing Reductions" box, you will be appealing your Advance Premium Tax Credit and Cost Sharing Reductions. Alternatively, by checking the "Only Medicaid/CHP+" box, you will be appealing your Medicaid/CHP+ determination. By checking "Both" or "I'm not sure" you will be appealing your Advance Premium Tax Credit (including Cost Sharing Reductions) and Medicaid/CHP+ determination.

- ☐ I am appealing Both the Advance Premium Tax Credit (including Cost Sharing Reductions) and Medicaid/CHP+
- ☐ I am appealing Only the Advance Premium Tax Credit Program and Cost Sharing Reductions
- ☐ I am appealing Only Medicaid/CHP+
- ☐ I'm not sure (this will result in an appeal of both Medicaid/CHP+ and the Advance Premium Tax Credit (including Cost Sharing Reductions)

Additional information regarding appeals was provided to you on your eligibility determination notice.

Is this an expedited appeal? ☐ Yes ☐ No

Expedited appeals are required when there is an immediate need for health services because the standard appeals process could seriously jeopradize the appellant's life or health, or ability to attain, maintain, or regain maximum function. Appeals that do not meet this criterion will be processed within the standard timeframe.

Please include any other details you would like to tell us regarding your appeal. We recommend you do not include sensitive information in this field.

[1] An Advanced Premium Tax Credit (APTC) is a new kind of financial help that you can use to lower your monthly cost for insurance, or premium, and Cost-Sharing Reductions (CSR) is support to lower your out-of-pocket costs, like copayments and deductibles, on your health care services. If you think you were incorrectly denied APTC/CSR, or the APTC/CSR you were received was terminated incorrectly, check this box.

STEP 3: Authorized Representative

If you previously designated an authorized representative or would like to designate an authorized representative, please complete the appropriate section in the attached authorized representative form:

The authorized representative form will allow you to:

- Add an Authorized Representative to your account.
- Revoke your permission for your current Authorized Representative.
- Change your Authorized Representative.

STEP 4: Accessibility

Do you need a language interpreter?	If **Yes**, for which language?
☐ **Yes** ☐ **No**	

Do you need this appeal form and subsequent appeals notices in a different format? If applicable, please check the box of the alternative format:

- ☐ Spanish
- ☐ Large Font
- ☐ Braille
- ☐ Other: _____

In follow-up interactions, will you need any of the following accessibility services?

- ☐ An interpreter
- ☐ TTY, Video relay, Skype for American Sign language

I understand that Connect for Health Colorado and/ or Colorado Department of Health Care Policy and Financing will use the information that I have provided here, as well as information that I have provided previously, to make an appeals determination. This information will only be shared internally within the appeals divisions and externally with appropriate adjudicators as required by law.

Failure to provide accurate and complete information will affect the appeals determination. If I choose to withdraw my appeal request, I will contact Connect for Health Colorado.

Appellant or Appellant Representative signature:	Date: (mm/dd/yyyy)