APPEAL REQUEST FORM

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

- Upload it to "My Documents" in your Connect for Health Colorado online account. (Make sure you tag it as an appeal request using the drop-down description of the document.)
- Mail it to:
  Connect for Health Colorado
  Office of Appeals
  4600 South Ulster Street, Suite 300
  Denver, CO, 80237
- Fax it to: Connect for Health Colorado Office of Appeals 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, the eligibility of other members of your household may also change. The Exchange 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 Exchange:

STEP 1: Appellant Information

1. Appellant First name, Middle name, Last name, & Suffix	Exchange 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 Preferred phone number: ☐ **Yes** ☐ **No**
15. Evening Phone number **( )** - Ext._____	Phone Type: ☐ Cell ☐ Home ☐ Work Preferred 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 Preferred phone number: **Yes** **No**
20. Evening number of authorized Representative **( )** - Ext._____	Phone Type: ☐ Cell ☐ Home ☐ Work Preferred phone number: ☐ **Yes** ☐ **No**

21. Preferred hours to contact authorized Representative (if applicable)

STEP 2: Appeal Information

Type of appeal (check all boxes that apply):

- ☐ Eligibility for, or amount of, APTC/CSR is incorrect.[1]
  - Amount or type of income used to determine eligibility is incorrect
  - People included in my household is/are incorrect
- ☐ Denial of SEP
  - Denied by the health insurance company (usually, this is when they cannot verify you qualify for SEP)
  - Denied by Connect for Health Colorado
- ☐ Eligibility to buy a QHP incorrectly determined
  - Incarcerated
  - Ability to buy catastrophic v. other metal level
  - Citizenship
- ☐ Notice failure
  - No eligibility determination notice was received
  - Multiple eligibility determination notices were received

Is this an expedited appeal? ☐ Yes ☐ No

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

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

[1] An Advanced Premium Tax Credit (APTC) is a kind of financial help that you can use to lower your monthly cost for insurance premium, and Cost-Sharing Reductions (CSR) is support to lower your out-of-pocket costs, like copayments and deductibles, on your health care services.

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)