Appeal Request Form

You can request a hearing with a judge, if you think we made a mistake about you or your family members' eligibility. By filling out this form, you are requesting a hearing with a judge. **Requesting an appeal is time sensitive!** Be sure you send this form in less than 90 calendar days from the date on the eligibility notice that you are disputing.

Application ID	Today's date (mm/dd/yyyy)	Date on eligibility notice

Appellant Information

(An "appellant" is the person requesting an appeal. The appellant should be the primary applicant on your *Washington Healthplanfinder* application.)

First name	Middle initial	Last name

Date of birth (mm/dd/yyyy)	Daytime phone number ( )	Email address

Street address	Apt./Ste. #

City	State	Zip code

What is the best way to contact you?
❑ Email ❑ Telephone ❑ Mail

Reasons for Filing an Appeal

❑ *Healthplanfinder* eligibility for or the amount of:

- Health Insurance Premium Tax Credit
- Cost Sharing
- Special Enrollment Period

Mail Appeal to:

Washington Health Benefit Exchange Appeals
PO Box 1757, Olympia, WA 98507-1757
Fax: 360-841-7653
Questions: 1-855-859-2512

❑ Washington Apple Health (Medicaid) eligibility.

❑ I would like to keep my Washington Apple Health coverage during the appeals process.

Washington Apple Health
PO Box 45504, Olympia, WA 98504-5504

Apple Health questions: 1-855-623-9357

*You must send this form within 10 days of receiving the eligibility notice or before your coverage ends.

Briefly Explain the Reasons for Your Appeal

Why do you want a hearing?

Authorized Representative (Optional)

You may have a relative, friend, legal counsel, or another spokesperson, including an authorized representative, help you file this appeal or participate in your appeal. If you choose to name an authorized representative, you're giving this person permission to talk with us about your appeal.

Name of Authorized Representative (first name, middle initial, last name)		
Daytime phone number	Alternative phone number	Email address
Street address		Apt./Ste. #
City	State	Zip code

Representative's relationship to you (check all that apply)

- ❑ Attorney/Legal Counsel
- ❑ Employer
- ❑ Family member of friend
- ❑ Tribal representative
- ❑ Insurance agent, broker, or navigator
- ❑ Legal Guardian/Power of Attorney
- ❑ Legal consultant or advocate (not an attorney)
- ❑ Other:

How Can We Help?

Appeals hearings are in English, unless you request an interpreter or other accommodations.

Do you want your notices in a language other than English? ❑ Yes ❑ No	If yes, what language?
Do you want an interpreter at no cost? (Friends and family members cannot act as your interpreter.) ❑ Yes ❑ No	If yes, what language?

Do you need other accommodations or help because of a disability?
❑ Yes ❑ No

If yes, please describe what you need:

Tribal Affiliation

Are you a member of a federally recognized tribe? ❑ Yes ❑ No	Is yes, what tribe?

Read and Sign Below (Required)

My signature below is my request for a hearing before a judge. I disagree with the decision about my eligibility. The information provided in this form is true and correct, to the best of my knowledge. I understand that this appeal request may be forwarded to the entity with the authority to handle my appeal.

Appellant signature **X**	Date of signature (mm/dd/yyyy)

Request an expedited appeal. The regular appeals process takes 30 – 90 days. You may request an expedited (faster) hearing if you have an immediate need for health services. If you request an expedited appeal, you must also include proof that the regular appeal process could jeopardize your life, health, or ability to maintain or regain maximum function. Contact Appeals at 1-855-859-2512 for more information.