



Virginia's Insurance Marketplace Appeal Request Form

Complete this form and submit it to Virginia's Insurance Marketplace. Your notice contains instructions about **"How to Submit an Appeal"**.

Note: Appeals of Medicaid and FAMIS eligibility must be submitted to the Virginia Department of Medical Assistance Services (DMAS). See your Appeals Rights Notice for more information. You may also contact DMAS by email: appeals@dmass.virginia.gov or by phone: (804) 371-8488 (TTY: 1-800-828-1120).

Get Help: If you need help filing an appeal or have additional questions about the appeal process, contact **Marketplace Customer Service at (888) 687-1501** or visit marketplace.virginia.gov/marketplace-help-center. Marketplace Customer Service representatives cannot provide legal advice, but they can answer questions about filing appeals and even assist with completing an Appeal Request form. If you need help with your appeal in a language other than English, please contact (888) 687-1501 and select 5 for Spanish or 8 for other languages.

STEP 1: IDENTIFY WHO IS APPEALING

Include ONLY the people on your Virginia's Insurance Marketplace application whose eligibility results are being appealed.

First Name	Last Name	
Date of Birth (mm/dd/yyyy)	Email (optional)	
Daytime Phone Number		
Street Address	Apartment or Suite Number	
City	State	Zip Code

If others on your application are appealing their eligibility results, fill in their names and dates of birth below. Include ONLY the people on your Virginia's Insurance Marketplace application whose eligibility results are being appealed. **Use extra pages if necessary.** Leave this section blank if no one else is appealing.

Additional Person Appealing

First Name		Last Name	
Relationship to Head of Household	Date of Birth (mm/dd/yyyy)	Email (optional)	

Additional Person Appealing

First Name		Last Name	
Relationship to Head of Household	Date of Birth (mm/dd/yyyy)	Email (optional)	

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Additional Person Appealing

First Name		Last Name	
Relationship to Head of Household	Date of Birth (mm/dd/yyyy)	Email (optional)	

STEP 2: IDENTIFY THE REASON FOR THE APPEAL

Review your eligibility determination notice and provide the following information.

Application ID # (printed on the first page of notice)	Date of the Notice You Are Appealing (mm/dd/yyyy)
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Select the reason(s) why you are appealing your eligibility result.

- ☐ Virginia's Insurance Marketplace determined that I, or another person on my application, was not eligible for coverage.
- ☐ Virginia's Insurance Marketplace determined that I, or another person on my application, was not eligible for financial assistance (advance premium tax credits or cost-sharing reductions).
- ☐ I disagree with the amount of financial assistance (advance premium tax credits or cost-sharing reductions) for which I, or another person on my application, was found eligible.
- ☐ Virginia's Insurance Marketplace determined that I, or another person on my application was not eligible for a Special Enrollment Period.
- ☐ Virginia's Insurance Marketplace did not provide a timely eligibility determination after I, or another person on my application, applied for coverage.
- ☐ Other (provide details below. Use additional pages if necessary).



STEP 3: TELL US MORE ABOUT YOUR APPEAL REQUEST. If you want to include documents to support your appeal, attach or send one copy of each document with your Appeal Request form. Keep all original documents. Use extra pages if necessary.

STEP 4: ASK FOR AN EXPEDITED (FAST-TRACK) APPEAL IF YOU NEED ONE FOR A HEALTH REASON (OPTIONAL)

If you have an immediate need for health services, and a delay could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, you can ask for an expedited (fast-track) appeal. (For example, if you're currently in the hospital or urgently need medication).

☐ No, I am not requesting to expedite my appeal.

☐ Yes, I need an expedited (fast-track) appeal.

If you selected "Yes" above, explain the reason you are requesting an expedited appeal. Use additional pages if necessary. If you're including documents to support your request, send us one copy of each of your documents. Keep all original documents. Virginia's Insurance Marketplace will contact you to notify you if your appeal was approved for the expedited (fast-track) process.

**STEP 5: APPOINT A REPRESENTATIVE (OPTIONAL)**

You can choose an authorized representative to help you with your appeal. The Marketplace will not provide a lawyer for you. Your representative is a trusted person you choose who has permission to discuss your appeal with the Marketplace, see your information, and act for you on matters related to your appeal, such as signing your Appeal Request or making arguments on your behalf at the hearing.

Your authorized representative will act on your behalf on all matters related to your appeal. Your signature on this Appeal Request authorizes Virginia's Marketplace to communicate with your Authorized Representative about your appeal. All communications about your appeal will go to your authorized representative, not you. If you change your mind after you appoint a representative and you don't want the person to act on your behalf anymore, you must call or write Virginia's Marketplace to remove the person as your representative.

No, I'm not appointing an authorized representative.

☐ Yes, I'm appointing an authorized representative to help with my appeal.

If you selected "Yes" above, provide the following information.

Authorized Representative's First Name	Authorized Representative's Last Name	
Date of Birth (mm/dd/yyyy)	Email	
Daytime Phone Number		
Street Address	Apartment or Suite Number	
City	State	Zip Code
Organization name	ID Number (if applicable):	



STEP 6: SIGN THE FORM

This section indicates your approval to let Virginia's Insurance Marketplace share federal tax information and Social Security Administration information for use during an appeal. This section applies for all individuals signing below who are 18 or older. All tax filers on your application must sign this form.

During the appeals process, we may need to share with you, or your authorized representative, the information Virginia's Insurance Marketplace used to determine your eligibility. This information might include employment income information from a consumer reporting agency, information about income you receive from the Social Security Administration, and/or federal tax information from the Internal Revenue Service about members of your household, including information from your last filed federal income tax return. Virginia's Insurance Marketplace cannot share federal income tax information or monthly and annual Social Security Benefit information under Title II of the Social Security Act from the Social Security Administration to an authorized representative or other individuals without your consent. To give Virginia's Insurance Marketplace permission, please sign below.

Acknowledgement Statement

I understand by completing, signing, and dating below, I authorize Virginia's Insurance Marketplace to disclose to the individuals whose signatures are provided below, as well as to any authorized representative, any federal tax information in my eligibility record which was provided by the Internal Revenue Service. I also consent to the release by Virginia's Insurance Marketplace of my monthly and annual Social Security Benefit information under Title II of the Social Security Act to these same individuals along with other information in my Virginia's Insurance Marketplace eligibility record, collected based on the application I filled out (or was completed for me) or that listed me as a household member, and from other data sources like income and employment verification from a consumer reporting agency that were used to make the Virginia's Insurance Marketplace eligibility determination.

I understand I can request a copy of my Virginia's Insurance Marketplace eligibility appeal record during the appeals process.

All tax filers in the household must consent to the disclosure of their own federal tax information and consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

This authorization is valid until the earliest date:

- the resolution of the appeal; or
- any written notification that I want any or all my authorized representatives removed from this appeal.

I'm signing this form under penalty of perjury, which means I've provided true answers to all the questions, and 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.

Head of Household on the Application / Tax Filer 1

Name (First Name, Last Name)	
Signature (an electronic signature is also acceptable)	Date (mm/dd/yyyy)



Additional Tax Filer on the Application / Tax Filer 2

Name (First Name, Last Name)	
Signature (an electronic signature is also acceptable)	Date (mm/dd/yyyy)

Additional Tax Filer on the Application / Tax Filer 3

Name (First Name, Last Name)	
Signature (an electronic signature is also acceptable)	Date (mm/dd/yyyy)