Appeal Request Form

You have the right to request an appeal if you think your *Washington Healthplanfinder* eligibility result is wrong. By filling out this form, you are requesting a hearing with a judge. **Requesting an appeal is time sensitive.** You have **90 calendar days** from the date on the eligibility notice you believe is wrong to request an appeal. Appeal within 10 days of the date on your eligibility notice to keep your Washington Apple Health (Medicaid) coverage. Appeal within 10 days of the date on your eligibility notice or within 10 days of the loss of your tax credit, child care sponsorship, or Cascade Care Savings if you want to keep your financial assistance during the appeal process.

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

Appellant information - The appellant is the person requesting an appeal

First name, middle initial, last name	Date of birth (mm/dd/yyyy)
Mailing address	Daytime phone number ( )
City, State, ZIP code	Email address

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

If your reason for appealing is:

❑ ***Washington Healthplanfinder* eligibility result (or amount of):**

- Health Insurance Premium Tax Credit
  - ❑ I would like to keep my tax credit during the appeal process and understand I will have to repay the IRS if I receive tax credits I'm not eligible for. **You must request your appeal within 10 days of the date on the eligibility notice or within 10 days of the date of the loss or reduction of tax credit.**
- Cost sharing reductions
- Special Enrollment Period
- Eligibility for AI/AN benefits through *Washington Healthplanfinder*.
- State premium assistance, such as child care worker sponsorship or Cascade Care Savings
  - ❑ I would like to keep my child care sponsorship or Cascade Care Savings during the appeal process. **You must request your appeal within 10 days of the date on the eligibility notice or within 10 days of the date of the loss or reduction of sponsorship/savings.**

Send your appeal to:

Washington Health Benefit Exchange
Appeals Program
PO Box 1757, Olympia, WA 98507-1757
Fax: 360-841-7653
Email: appeals@WAHBExchange.org

Questions? Call 1-855-859-2512 or email appeals@WAHBExchange.org

❑ **Washington Apple Health (Medicaid) eligibility**

- ❑ I would like to keep my Apple Health coverage during the appeal process. **You must request your appeal within 10 days of the date on your eligibility notice or before your coverage ends.**

Washington Apple Health Appeals
Mail: PO Box 45531, Olympia, WA 98504
Email: ASKMAGI@hca.wa.gov – *indicate "appeal" in the subject line*
Fax: 360-507-9020

Questions? Call 1-800-562-3022 or email ASKMAGI@hca.wa.gov

Briefly explain the reason for your appeal. Attach additional pages if necessary.

Authorized Representative (optional)

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

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

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

- ❑ Attorney/Legal Counsel
- ❑ Employer
- ❑ Family member or 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, written and spoken, unless you request translations, 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 accessibility assistance?
❑ 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

My signature here is my request for a hearing with a judge. I disagree with a decision about my Washington Healthplanfinder eligibility. The information provided on 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)

Requesting an expedited appeal. The regular appeal process takes 30 – 90 days. You may request an expedited (faster) hearing if you have an immediate need for health services. You must tell us if you want an expedited appeal, and you must include proof that the regular appeal process could jeopardize your life, health, or ability to maintain or regain maximum function. For more information.

Washington Health Benefit Exchange expedited appeal: call 1-855-859-2512 or appeals@WAHBExchange.org

Apple Health expedited appeal: call 1-800-562-3022