



MARKETPLACE APPEAL REQUEST FORM

- If you need help in another language or would like this form in another language, please refer to the last page of this document.
- If you need assistance filling out this form, please call (866) 311-1119.

Does your appeal need to be expedited? * Yes ☐ No ☐

** 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 appeal by calling 1-866-311-1119. Please provide a rationale for the expedited appeal request on page 3 of this form.*

Do you want to keep your coverage or financial help during your appeal? * Yes ☐ No ☐

** If you, or your family members, were disenrolled from Get Covered Illinois, you have a right to keep your coverage while you appeal. This is called Continued Enrollment. You can ask for Continued Enrollment at any time during the appeals process. See the Continued Enrollment form on page 8 for more information.*

Instructions for Filing an Appeal:

You have the right to a hearing if you disagree with a Get Covered Illinois eligibility decision. You may appeal if you believe Get Covered Illinois made an error in deciding your or your family member's eligibility.

If more than one family member wants to appeal, list each name so we know whose eligibility determination is being appealed.

To request a hearing with a Hearing Officer, complete this form and return it within 90 days of the date on your eligibility notice. To submit the form, send it to one of the methods listed below, or by calling 1-866-311-1119 (TTY: 711). Language help is available at the numbers listed at the end of this form.

Any personal information you provide will be kept private as required by Illinois law (see 5 ILCS 160/State Records Act, 815 ILCS 530/Personal Information Protection Act) and federal law (see 45 CFR § 155.260).

You can return the *Marketplace Appeal Request Form* in one of the ways listed below:

Go Online: Visit www.getcoveredillinois.gov and log in to your account. Once logged in, navigate to "My Tickets" and select "Submit New Ticket." Select the Request Type "Appeals" and Request Subtype "Appeal Requests." Provide a brief description and attach your Appeals Form to the ticket.

Fax to Get Covered Illinois at: (888) 973-8254

Mail your appeal to:
Get Covered Illinois
Attn: Marketplace Appeals Program
P.O. Box 804058
Chicago, IL 60680

If you need help submitting your appeal, call Get Covered Illinois at **1-866-311-1119** (TTY: 711), Monday to Friday, 8:00 AM to 6:00 PM Central Time.

If you use this form to appeal, the date of the postmark on the envelope or the date a fax or appeal ticket is created will be considered the date you filed your appeal. You may be able to file your appeal after the 90-day deadline if you have an exceptional circumstance for filing late. A member of the Get Covered Illinois Marketplace Appeals team will decide if there is a good reason for a late appeal.

If you appeal and we agree with you, we may change our decision prior to the actual hearing. If we change our decision,

it is possible that your family members' eligibility may also change, even if they do not file their own appeal.

Please keep a copy of all forms for your records

APPELLANT #1

(The *appellant* is the person whose eligibility is being appealed. This section should be filled out by the appellant or by a parent/guardian/Authorized Representative of the appellant.)

Household ID

First Name

Middle Initial

Last Name

Suffix

Date of Birth (mm/dd/yyyy)

Phone Number (with area code)

Email Address

Street Address

Apt./Ste. #

City

State

Zip Code

List the names of other household members who are filing an appeal using this form. If you need more space, attach extra paper or include the additional names in your uploaded form.

Household Member #2: First Name: _____ Last Name: _____ DOB: _____

Household Member #3: First Name: _____ Last Name: _____ DOB: _____

Household Member #4: First Name: _____ Last Name: _____ DOB: _____

Reasons for filing an appeal.

Your eligibility notice explains what you are eligible for and the programs for which you do not qualify. Depending on your eligibility results, you may appeal any of the following (check as many boxes as you would like):

My appeal is because my eligibility to purchase or use health insurance on the exchange was denied for the following reason(s):

- ☐ Not eligible to buy a Marketplace plan.
- ☐ Not eligible for savings, like advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSR).
- ☐ Eligible for APTC or CSR, but the amount is wrong.
- ☐ Not eligible for a Special Enrollment Period.
- ☐ A failure by Get Covered Illinois to provide timely notice of an eligibility determination.
- ☐ Get Covered Illinois removed my APTC and/or CSR due to not submitting verifications documentation in time.
- ☐ My coverage was terminated due to a mistake or error by Get Covered Illinois, an agent, or enrollment assister (does not include reinstatement due to termination by carrier for non-payment).
- ☐ Other (please specify): _____

Additional Information

Tell us more about why you disagree with Get Covered Illinois's decision. You may attach additional sheets if you need more room to provide your reasons.

If you are requesting an **expedited appeal**, please explain why it is urgent. You may attach additional sheets if you need more room to provide your reasons.

Correspondence Preference

Please select how you would like to receive correspondence related to your appeal.

- ☐ **Secure Inbox** – I prefer to receive appeal correspondence to my Get Covered Illinois account secure inbox with email notifications sent to the email address provided on this form.
- ☐ **Postal Mail** – I prefer to receive appeal correspondence by postal mail at the address provided on this form.

Important: Illinois law requires certain legal notices, including the Notice of Hearing, Motions and Answers, and the Final Decision, to be served by certified or registered mail, even if you select email. You may receive copies of these notices by email in addition to the required mailing. (see 50 Ill. Admin. Code 2402.90, 2402.100, 2402.270).

Privacy and use of your information. We will keep your information private as required by law. See the Privacy Act Statement below for more details.

Privacy Act Statement

The Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act authorize Get Covered Illinois (GCI) to collect the information on this form and any supporting documents, including a Social Security Number. This information is needed to process your appeal request and determine whether you or others listed on this form are eligible for health coverage, financial help (advance payments of the premium tax credit or cost-sharing reductions), or a certification of exemption from the requirement to have health coverage.

Get Covered Illinois will use the information you provide on this appeal form to:

- Review the decision you are appealing,
- Communicate with you or your Authorized Representative (if you choose to have one),
- Process your appeal request, and
- Carry out ongoing operations such as verifying eligibility, reporting on and managing financial help programs, conducting oversight and quality control, preventing fraud, and protecting the security and confidentiality of information.

Providing this information is voluntary. However, if you do not provide it, we may not be able to process your appeal or confirm eligibility for coverage or financial help. If you knowingly provide false or fraudulent information, you may face penalties or other law enforcement action. Get Covered Illinois will not share your immigration status for immigration enforcement purposes.

To process your appeal and operate Get Covered Illinois, we may share selected information with:

1. Federal and state agencies, such as the Internal Revenue Service (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS), Department of Health and Human Services (HHS), and the Illinois Department of Healthcare and Family Services (HFS);
2. Judicial review entities at the state or federal level, as allowed by law;
3. Contractors engaged to perform functions for Get Covered Illinois; and
4. Other parties as required by law.

This statement is provided in accordance with the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)).

You can learn more about how we handle your information at: <https://www.getcoveredillinois.gov/privacy>

Authorized Representative Form

Instructions: An **Authorized Representative** is someone you trust to help you with your application or appeal. They can see your personal information and act for you on matters related to this application, including getting information or signing the application. You may choose a family member, friend, attorney/lawyer, or organization to be your Authorized Representative. They can only act on your behalf for the matters you authorize.

To assign an Authorized Representative, complete this page and return it to Get Covered Illinois. You may also assign one by phone at 1-866-311-1119. If you need to change your Authorized Representative later, contact Get Covered Illinois.

Application ID		
Name of Authorized Representative or Name of the Organization		
Address		Apt./Ste. #
City	State	ZIP Code
Phone Number (with area code)		ID number (if applicable)
Email Address		

For Certified Enrollment Counselors, Agents, and Brokers acting as Authorized Representatives

First Name, Middle Name, Last Name, & Suffix
Organization Name (if applicable)

Permission to share information.

I, **as the applicant/enrollee**, authorize the person/organization above to act on my behalf regarding my application or appeal with Get Covered Illinois. I authorize Get Covered Illinois to speak with this person/organization on my behalf. I understand that this permission to act for me ends on the date that Get Covered Illinois sends me its decision regarding my application or appeal.

Do you want your Authorized Representative to receive notices on your behalf? Yes ☐ No ☐

What is your representative's preferred method of communication? Get Covered Illinois secure inbox ☐ **OR** US postal mail ☐

- ☐ I have signed and dated this form below.
- ☐ I understand that Get Covered Illinois cannot speak with the person/organization I have appointed above (my Authorized Representative) until it receives this signed form from me.

By signing, you allow this person to sign your application, get official information about this application, and act for you on future matters related to this application until the end of the appeals process.

Applicant's/Enrollee's signature	Date (mm/dd/yyyy)
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Authorized Representative declaration and signature. *This is required.*

By signing below, I hereby agree to the following conditions in order to serve as an Authorized Representative:

- ☐ I agree that I am legally bound to maintain the confidentiality of any information regarding the applicant or enrollee provided by Get Covered Illinois.
- ☐ I agree to be responsible for fulfilling all my responsibilities within the scope of the authorized representation to the same extent as the applicant or enrollee who I represent; and
- ☐ I agree to comply with all applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative's signature	Date (mm/dd/yyyy)
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Next Steps: What to Expect

1. Acknowledgment letter of your appeal request and further instructions. You will receive an acknowledgment letter and instructions after we receive your appeal. A member of the Get Covered Illinois Marketplace Appeals team will review your request to confirm it is complete. If information is missing or unclear, we will notify you and provide a deadline to supply or correct the information.

2. Review of your information. You have the right to review the information being used to decide your appeal, including the information in your Get Covered Illinois online account.

3. Submitting additional information. You may submit additional information to support your appeal. We will review it along with the information originally used to make your eligibility determination. You may submit documents with this form or provide them before or at the hearing. You also have the right to provide additional information about your case to the Hearing Officer before or at the time of the hearing.

4. Informal resolution. Before your hearing, we may try to resolve your appeal informally by reviewing your case and discussing it with you. If we change our decision, you will receive an informal resolution offer. If you agree to the informal resolution offer, you can sign and return an agreement form or verbally agree. If you agree, it will end the appeal. If you disagree, your appeal will continue to a hearing.

5. Hearing. Hearings are held by phone or video conference. If you prefer an in-person hearing, you must contact your Hearing Officer to request one.

You may represent yourself or be represented by a lawyer, friend, relative, Authorized Representative, or another individual.

You have the right to review all information considered by the Hearing Officer. Get Covered Illinois will send you an **evidence packet** at least five (5) business days before your hearing. This packet includes documents used to make the eligibility determination, any supporting information submitted, and other materials the Hearing Officer will review. The same information will also be available in your online account.

After the hearing, the Illinois Department of Insurance Director will issue a final written decision, which will be mailed to you.

If you need an interpreter or disability accommodations, contact the Get Covered Illinois Customer Assistance Center at 1-866-311-1119 (TTY 711).

If you do not attend your scheduled hearing and do not withdraw in advance, your appeal will be dismissed unless you show good cause for missing it.

If you need to postpone your hearing, contact your Hearing Officer using the information in your scheduling notice.

6. Expedited Appeals: If you believe your situation requires urgent attention, you may request an expedited appeal. See the instructions on this form or contact the Get Covered Illinois Customer Assistance Center for guidance.

7. Second-Level Appeal Options. If you disagree with the Director's final decision, you may:

- File an appeal with the **U.S. Department of Health and Human Services (HHS)** within 30 days of the decision:

Health Insurance Marketplace

Attn: Appeals
465 Industrial Boulevard
London, KY 40750-0061
Phone: 1-800-318-2596
(TTY: 1-855-889-4325)

If HHS rules in your favor, Get Covered Illinois must comply with that decision.

- File an appeal in **Illinois Circuit Court** within 30 days of receiving your decision.

8. Continued Enrollment during your appeal. If you are appealing coverage termination or an eligibility redetermination, you may request **Continued Enrollment** to keep your plan and financial help while the appeal is pending. To request this, complete page 7 of this form. Continued Enrollment requires acceptance of your appeal, and you will be notified if it is approved.

9. Privacy of Your Information. All personal information you provide will be kept private as required by law. For details, see the *Privacy Act Statement* in this form.

10. Appeals FAQs. For more information about the Get Covered Illinois Marketplace Appeals Program, visit: www.getcoveredillinois.gov/appeals.

Continued Enrollment Form (optional)

Instructions

If you appealed an eligibility redetermination with Get Covered Illinois, you may request to keep your coverage while your appeal is being reviewed. This is called Continued Enrollment.

If approved, Get Covered Illinois will re-enroll you, and coverage will start on the first day of the month in which your appeal was filed. You must continue to pay your premiums to keep your coverage.

Application ID

First Name	Middle Initial	Last Name	Suffix
Date of Birth (mm/dd/yyyy)		Phone Number (with area code)	
Email Address			
Street Address			Apt./Ste. #
City	State	Zip Code	

Check one:

- ☐ I would like to be enrolled into my previous Get Covered Illinois health plan from the first day of the month during which Get Covered Illinois received my valid appeal request. If I am retroactively enrolled, I understand that I will have to pay any past-due premiums.
- ☐ My coverage will soon be terminated. I would like to continue my coverage while my appeal is being reviewed. I understand that I will need to continue making my premium payments while my appeal is being reviewed.
- ☐ I am not losing my coverage, but I am appealing my Advanced Premium Tax Credit (APTC) amount or Cost-Sharing Reduction (CSR) level. I would like my financial help to stay the same while my appeal is being reviewed.

Sign the form and send it to us before your hearing date.

By signing this form, I am requesting to keep my coverage while my appeal is being reviewed (**Continued Enrollment**). I understand that I must pay my monthly premiums during this period. I also understand that if I do not make the payments, I or my family members may lose coverage.

I understand that if I receive more premium assistance than I am eligible for during the benefit year, including during the Continued Enrollment period, I may have to repay the excess to the IRS when I file my federal income tax return.

Signature: _____ **Date:** _____

Mail this form to:
Get Covered Illinois
Attn: Marketplace Appeals
Program
P.O. Box 804058
Chicago, IL 60680

Fax this form to:
Get Covered Illinois
(888) 973-8254

**Call the Get
Covered
Illinois
Customer
Assistance
Center at:**
(866) 311-
1119

**Upload this form to your Get
Covered Illinois account**

Getting Help in a Language Other than English

If you, or someone you're helping, has questions about Get Covered Illinois, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-866-311-1119, TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Get Covered Illinois, tiene derecho a obtener ayuda información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-311-1119, TTY 711.

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Get Covered Illinois, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-866-311-1119, TTY 711.

如果您，或您正在幫助的人，有關於 Get Covered Illinois 方面的問題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電 1-866-311-1119, TTY 711。

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Get Covered Illinois 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-311-1119, TTY 711 로 전화하십시오.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Get Covered Illinois, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-311-1119, TTY 711.

لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة، للحصول على Get Covered Illinois، إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص 1119-311-866-1 مع مترجم اتصل بـ 1119-311-866-1, TTY 711.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Get Covered Illinois, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-866-311-1119, TTY 711.

જો તમને અથવા તમે મદદ કરી રહ્યા છો તેવા કોઈને Get Covered Illinois. વિશે પ્રશ્નો હોય, તો મદદ અને માહિતી મેળવવા માટે તમારું સ્વાગત છે. મદદ તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવી શકાય છે. મુદ્દાઓની ચર્ચા કરવા માટે, [અહીં નંબર દાખલ કરો] પર કોલ કરો.

تو آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق، Get Covered Illinois، اگر آپ کسی کی مدد کر رہے ہیں اور آپ کے بارے میں کوئی سوال ہے ہے۔ مترجم سے بات کریں۔

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Get Covered Illinois, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-311-1119, TTY 711.

Se tu o qualcuno che stai aiutando avete domande su Get Covered Illinois, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-866-311-1119, TTY 711.

यदि आपको, या आप जिस व्यक्ति की सहायिा कर रहे हैं, उन्हें इस विषय Get Covered Illinois के बारे में सवाल हैं, तो आपको मुफ़्ति में अपनी भाषा में सहायिा िथा िानकारी लेने का अधिकार है। 1-866-311-1119, TTY 711 पर फ़ोन करें

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Get Covered Illinois, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-866-311-1119, TTY 711.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Get Covered Illinois , έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-866-311-1119, TTY 711.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Get Covered Illinois haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-311-1119, TTY 711 an.