





Instructions to help you complete the Marketplace Eligibility and Financial Assistance Appeal Request

-  **Use this form to request an appeal**
- **Complete and mail this request form for your appeal.**
 - If you have an immediate need for health services and a delay could seriously jeopardize your health, you can ask for an expedited (faster) appeal review. (See Step 5).

-  **Time frame to request an appeal**
- You must submit your appeal request **within 90 days** of the date on the eligibility determination notice that you are appealing.

-  **How to submit this form**
- Enter your information directly, then print your completed form. Or, print a blank form to fill in by hand using black or dark blue ink.
- Sign the completed form and mail together with any supporting documents to:
- Get Covered New Jersey**
Attn: Appeals
PO Box 55898
Trenton, NJ 08638

-  **What happens next?**
1. We will send you a notice letting you know that we received your appeal request and if anything is missing.
 2. We will review your appeal, including all documentation you have provided. We may contact you to request additional information or to discuss your appeal.
 3. We may ask if you want to resolve your appeal informally. If you are satisfied with your informal resolution, you will get an informal resolution decision in the mail.
 4. If you are not satisfied with your informal resolution, you can ask us to schedule a hearing for your appeal. Hearings are handled by the New Jersey Office of Administrative Law. Most hearings are held over the phone. If you don't attend your hearing, your appeal will be dismissed.
 5. After your hearing, you will get a final appeal decision.



Additional help

Language assistance services

If you need help with your appeal in a language other than English, you have the right to get information in your language at no cost. Call the Call Center at 1-833-677-1010.

Accessibility

If you need assistance with accessing appeals forms, you can contact the Call Center at 1-833-677-1010. TTY users can call 711. You can also make a request in writing by mail (Get Covered New Jersey, Attn. Appeals, P.O. Box 55898, Trenton, NJ 08638). Accommodations are provided at no cost to you.

To submit your appeal request, see “How to submit this form” on page 1 of these instructions.



Choose an Authorized representative

You have the right to choose an authorized representative to help you with your appeal. This is a trusted person who has your permission to talk with us about your appeal, see your information, and act for you on matters related to your appeal, including getting information about you and signing your appeal request on your behalf.

To appoint an authorized representative, complete and mail the form “Appoint an authorized representative for my appeal,” at the bottom of this application. If you already completed an authorized representative form for your Marketplace application, you need to complete an additional form for your appeal.



Questions

To learn more about your appeal, contact the Call Center at 1-833-677-1010. TTY users can call 711.

Privacy and Use of Your Information

Get Covered New Jersey protects the privacy and security of information about you that you’ve provided. To view the Privacy Policy, go to [getcovered.nj.gov](https://www.getcovered.nj.gov).

Nondiscrimination

Get Covered New Jersey doesn’t exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you’ve been discriminated against or treated unfairly for any of these reasons, you can file a complaint by contacting the GetCoveredNJ Call Center 1-833-677-1010 (TTY: 711) or with the U.S. Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting [hhs.gov/ocr/civilrights/complaints](https://www.hhs.gov/ocr/civilrights/complaints), or writing to the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201

To help the Marketplace Appeals Center process your appeal, refer to the table below about the types of documents to submit with your appeal request. **Submit copies and not original documents, since your original documents will not be returned.** Write your first and last name on any documents you send with your appeal request.

Reason you are appealing	Examples of supporting documents to include with your appeal request
<p>You lost financial assistance for your Marketplace coverage because the Marketplace told you that you did not submit documents proving your household income.</p>	<ul style="list-style-type: none"> • Tax returns (e.g. 1040, 1040A, 1040EZ) • Pay stubs, W-2s, or 1099s • Self-employment ledgers (including the name of the person earning the income, the company’s name, the dates for which the income is received, and the net amount of profit or loss) • Social security benefits statements
<p>You lost financial assistance for your Marketplace coverage because the Marketplace told you that you did not submit documents proving that you were ineligible for other types of health coverage.</p>	<ul style="list-style-type: none"> • Medicaid – letter from your state’s Medicaid agency or Children’s Health Insurance Program (CHIP) stating you are not eligible for Medicaid or CHIP • Department of Veterans Affairs (VA) – letter from VA stating you are not enrolled in health coverage • Employer coverage (including COBRA) – letter from health insurance company or employer stating you were ineligible or showing termination information • TRICARE – letter from Department of Defense Health Agency stating you are not eligible for health coverage • Peace Corps – letter from Peace Corps stating you are not eligible for health coverage • Medicare – letter from the Centers for Medicare & Medicaid Services (CMS) or Social Security Administration (SSA) stating you are not eligible for Medicare
<p>You lost your coverage because the Marketplace told you that you did not submit documents proving your citizenship or immigration status.</p>	<ul style="list-style-type: none"> • Permanent Resident Card (I-551) • Employment Authorization Card (I-766) • United States and Unexpired Foreign Passports • Driver’s Licenses or State ID along with US Birth Certificate • Notice of Action (I-797) • Departure Record (I-94) • Certificate of Citizenship (N-560/N-561) • American Indian Card (I-872) • School records showing the child’s name and U.S. place of birth along with a school photograph ID
<p>The Marketplace told you that you were not eligible to enroll in or change plans through the Marketplace outside of an open enrollment period.</p>	<p>The reason you believe you should be allowed to enroll is because you:</p> <ul style="list-style-type: none"> • Lost or are losing coverage – letter from the insurance company, or the agency which administered the insurance, showing the last day of coverage • Were denied Medicaid or Children’s Health Insurance Program (CHIP) – denial or termination letter from NJ FamilyCare • Got married – marriage certificate, marriage license, or signed affidavit • Had a baby, adopted a child, or placed a child for foster care – birth certificate, hospital records, adoption certificate, child support order, or court order • Had a permanent move – driver’s license, state ID, lease agreement, mortgage payment receipt, or utility bill

STEP 7: Signature.

This information applies for all individuals signing below who are 18 or older.

Your approval to let Get Covered New Jersey share federal tax information, Social Security Administration information, and other relevant personal information for use during an appeal.

During your appeal, we may need to share with you or your authorized representative and appeal authority the information GetCoveredNJ 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 federal tax information from the Internal Revenue Service about members of your household, including information from your last filed federal income tax return. The 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. Sign below to give your consent.

I understand by completing, signing, and dating below, I authorize the Marketplace to disclose to the individuals whose signatures are provided below as well as any authorized representative and the appeals authority any federal tax information in my eligibility record which was provided by the Internal Revenue Service. I also consent to the release by GetCoveredNJ 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 GetCoveredNJ 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 Marketplace eligibility determination.

I understand I can request a copy of my GetCoveredNJ eligibility appeal record during the appeals process.

Each adult member of the household must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act and other personal information related to the appeal by signing below.

The authorization is valid until the resolution of the appeal.

I understand that I must notify Get Covered New Jersey, in writing, if I wish to remove my authorized representative.

I am signing this form under penalty of perjury, which means I have provided true answers to all the questions, and I have answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

Signature

1. Printed name (First Name, Middle Name, Last Name)

	Date (mm/dd/yyyy)					
	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					

Signatures of everyone you listed in Section 1 who is 18 and older

2. Printed name (First Name, Middle Name, Last Name)

	Date (mm/dd/yyyy)					
	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					

3. Printed name (First Name, Middle Name, Last Name)

	Date (mm/dd/yyyy)					
	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					

STEP 7: Signature (Continued)

This information applies for all individuals signing below who are 18 or older.

4. Printed name (First Name, Middle Name, Last Name)

Signature

Date (mm/dd/yyyy)

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Signatures of any other household members listed on the application for Marketplace coverage

Even if they're not included in this appeal, each adult member of the household who is 18 and older must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

5. Printed name (First Name, Middle Name, Last Name)

Signature

Date (mm/dd/yyyy)

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6. Printed name (First Name, Middle Name, Last Name)

Signature

Date (mm/dd/yyyy)

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7. Printed name (First Name, Middle Name, Last Name)

Signature

Date (mm/dd/yyyy)

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8. Printed name (First Name, Middle Name, Last Name)

Signature

Date (mm/dd/yyyy)

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Optional Form

Appoint an authorized representative for my appeal

You have the right to choose an authorized representative to help you with an eligibility appeal. An "Authorized Representative" is a person/organization you trust to help you with your application or appeal with us, who is able to see your personal information and to act for you on matters related to this application (including getting information about your application or signing your application on your behalf). If you would like to assign an Authorized Representative to act on your behalf, complete this page and return it to us. If you ever need to change your Authorized Representative, contact GetCoveredNJ. If you would like to assign your Authorized Representative over the phone, call us at 1-833-677-1010.

Make a copy for your records and mail the completed form to:

Get Covered New Jersey
Attn: Appeals
PO Box 55898
Trenton, NJ 08638

STEP 1: Enter information for the person who's requesting an appeal (also called an "appellant").

First name	Middle name
<input type="text"/>	<input type="text"/>
Last name	Date of birth (mm/dd/yyyy)
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Appeal Case ID # (if you have one)	
APL- <input type="text"/>	

STEP 2: Enter information for the authorized representative.

By appointing an authorized representative, you are requesting that the Get Covered New Jersey Appeals Center send all communications (including email or text message reminders) to your representative instead of you.

Authorized representative's first name	Middle name	
<input type="text"/>	<input type="text"/>	
Last name		
<input type="text"/>		
Mailing address	apartment or suite number	
<input type="text"/>	<input type="text"/>	
City	State	ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone number with area code		
() <input type="text"/>		
Organization name (if applicable)		
<input type="text"/>		

