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
You lost financial assistance for your Marketplace coverage because the Marketplace told you that you did not submit documents proving your household income.	• 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
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.	• 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
You lost your coverage because the Marketplace told you that you did not submit documents proving your citizenship or immigration status.	• 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
The Marketplace told you that you were not eligible to enroll in or change plans through the Marketplace outside of an open enrollment period.	The reason you believe you should be allowed to enroll is because you: • 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 2: Electronic reminders.

Do you want to get email updates about your appeal when available? If so, please select preferred communication method (notifications will not contain personal health information).

Get appeal reminders by:

☐**Email (Remember to check your spam folder) Email Address**

☐ **No reminders**

STEP 3: Tell us your preferred hearing method.

Do you want to have your appeal: ☐ by telephone ☐ in-person at a hearing location

Do you need any assistance for your appeal hearing, including interpreter services or assistance with access or accommodations for your full participation in the appeal? (These will be provided free of charge.) Explain below:

STEP 4: For consumers who were eligible for Marketplace coverage last year, and are appealing a redetermination of their eligibility for a qualified health plan with financial assistance:

If you and your household members would like to continue your prior eligibility and enrollment during this appeal, Get Covered New Jersey will continue your household's enrollment in your health plan as well as the advance payments of the premium tax credits, and cost-sharing reductions, if applicable, in accordance with the level of eligibility immediately before the redetermination being appealed. Please confirm below:

____I/we wish to continue prior year coverage pending the appeal with prior year premium tax credits. If I/we are determined ineligible for any tax credits for this continued eligibility period during the appeal, they will be paid back to the Internal Revenue Service.

STEP 5: Tell us why you are appealing.

What's the date of the notice you are appealing? (mm/dd/yyyy)

What's the Application ID # (printed on the first page of the notice)?

Select each appeal reason that applies to you or someone in your household.

☐Marketplace determined that I was not eligible for coverage.

☐I lost financial assistance for my Marketplace coverage, also called advance payments of the premium tax credit or cost- sharing reductions.

☐I disagree with the amount of financial assistance (advance payments of the premium tax credit, New Jersey subsidy or cost-sharing reductions) that I was found eligible for.

☐Marketplace determined that I wasn't eligible to enroll in or change plans through the Marketplace outside of an open enrollment period.

☐Marketplace did not provide a timely eligibility determination after I applied for coverage.

Enter the date of your application, if available. (mm/dd/yyyy)

STEP 5: Tell us more about why you are requesting this appeal.

Use extra paper if necessary. If you are including documents to support your request, send us one copy of each of your documents. Keep all original documents.

STEP 6: Ask for a faster appeal if you need one.

If you have an immediate need for health services, and a delay could seriously jeopardize your life, health, or ability to attain, maintain, or retain maximum function, you can ask for an expedited (faster) appeal review.

☐ **I need an expedited appeal.**

Explain the reason you need an expedited appeal. Write the reason for this request in the space below. Use extra paper if necessary. If you're including documents to support your request, send us one copy of each of your documents. Keep all origi documents.

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)

Signature

Date (mm/dd/yyyy)

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

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

Signature

Date (mm/dd/yyyy)

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

Signature

Date (mm/dd/yyyy)

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)**

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)**

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

Signature **Date (mm/dd/yyyy)**

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

Signature **Date (mm/dd/yyyy)**

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

Signature **Date (mm/dd/yyyy)**

11/2020
Form Approved
Appoint an Authorized
REPRESENTATIVE FOR MY APPEAL

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

Last name

Date of birth (mm/dd/yyyy)

Appeal Case ID # (if you have one)

APL–

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

Last name

Mailing address

apartment or suite number

City

State

ZIP code

Phone number with area code

( )

Organization name (if applicable)

STEP 3: Electronic reminders.

If your authorized representative would like to receive electronic reminders about your appeal, when available, please have them provide their signature below, as well as the preferred method of correspondence (notifications will not contain personal health information).

Mobile number

( ) For privacy information, please visit: **getcovered.nj.gov**

◯ **Email (Remember to check your spam folder)**

Email Address

◯ **No reminders**

Authorized Representative printed name (if choosing to receive electronic reminders) (First name, Middle name, Last name)

Signature **Date Signed (mm/dd/yyyy)**

STEP 4: Signature.

By signing below, you allow the person named in Step 2 to sign your appeal request, get official information about your appeal, and/or act for you on all future matters related to this appeal.

Appellant printed name (First name, Middle name, Last name)

Signature **Date Signed (mm/dd/yyyy)**

To change or remove your authorized representative, or for more information, contact the Get Covered New Jersey Call Center at 1-833-677-1010. TTY users can call 711.

If you believe that Get Covered New Jersey has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Get Covered New Jersey by calling the call center (1-833-677-1010) or by writing to the Get Covered New Jersey Consumer Assistance Center, PO Box 55898, Trenton, NJ 08638. If you need help filing a grievance, the call center can help you.