Maine Eligibility Appeals Request Form



Important Information about Marketplace Appeals

If you don't agree with a decision made by CoverME.gov, you may be able to file an appeal. You generally have **90 days** from the date of your Eligibility Notice to ask for an appeal.

Before submitting an Appeals Request Form, please review the list below.

Marketplace decisions you can appeal:

The Division of Administrative Hearings can review these types of issues:

- Special Enrollment Period (SEP) Denial
- Not eligible for advance payments of the premium tax credit (APTC)
- Eligible for APTC, but the amount is wrong
- Enrollment Denial (Not eligible to buy a Marketplace plan through CoverME.gov)

Decisions you **can't appeal** through the Marketplace:

The Division of Administrative Hearing can't review these types of issues:

- You disagree with the date the Marketplace ended your coverage.
- Your health plan company didn't apply your premium tax credits correctly.
- You want to change information on your Marketplace application.
- You believe your health plan owes you a refund.
- You want to end your health plan on an earlier date.
- You disagree with information on your Form 1095-A, or want a corrected form.
- Your health plan refuses to pay a claim you think should be covered.
- When you filed your federal income tax return, you owed back some or all of the premium tax credits you used during the year to lower your monthly premiums.



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Request for Independent External Appeal of a Denied Eligibility Claim

Section I - Applicant Information			
Applicant's Name:		<u> </u>	
Applicant's Email:		<u> </u>	
Applicant's Mailing Address:			
City:	State:	Zip Code:	
Applicant's Phone Number(s): Dayti	me:()	Evening: ()
CoverME.gov ID:			
Signature:	Date: _		
Section II - Appointment of Author	ized Representati	ve (Optional)	
** Complete this section only if som	eone else is repres	senting the applicant in this a	appeal **
You may represent yourself or you m You may revoke this authorization a		rson to act as your personal	representative.
I hereby authorize		to pursue my appeal o	on my behalf.
Signature of Applicant (or legal repr	esentative - Pleas	e specify relationship or title	e)
Representative's Mailing Address: _			
City:	State:	Zip Code:	
Representative's Phone Number(s):	Daytime: () Evenii	ng:()



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Section III - Eligibility Decision in Dispute

I am requesting a hearing because I disagree with the following action(s):

Please check the box of all situations that apply.
Special Enrollment Period (SEP) Denial Not eligible for advance payments of the premium tax credit (APTC) Eligible for APTC, but the amount is wrong Enrollment Denial (Not eligible to buy a Marketplace plan through CoverME.gov) Cost-Sharing Reduction (CSR) Denial or Calculation
How do you want the agency's decision to be changed?
List by name all others in your household whose benefits determination you are also appealing:
(APTC/CSR Cases Only): How much APTC where you approved for? \$ max/month
How much CSR were you approved for? %
Do you want to receive APTC/CSR while your appeal is pending? Yes No
<i>Note</i> : If you select this option, and the result of your appeal is that you are determined eligible follows, or no premium tax credit, the amount you received while your appeal is pending may lead to you owing more federal taxes or it may reduce the refund you would have otherwise received.
Section IV - Expedited Review
** Complete this section only if you would like to request expedited review **
The applicant or appointed representative may request that the external review be handled on a expedited basis.
Do you request an expedited review? Yes No





Section V - Mail Information

Please mail this Eligibility Appeals Request Form to:

CoverME.gov Consumer Assistance Center

P.O. Box 616

Augusta, ME 04332-6626