Maine Eligibility Appeals Request Form

Request for Independent External Appeal of a Denied Eligibility Claim

Section I – Applicant Information

Applicant's Name:________________________

Applicant's Email: ________________________

Applicant's Mailing Address: ____

City:___________________State:_____Zip Code: _________

Applicant's Phone Number(s): Daytime: ( )____________ Evening: ( )______________

CoverME.gov ID: ________________

Signature: _______________________________ Date: _________________________

Section II – Appointment of Authorized Representative

** Complete this section only if someone else is representing the applicant in this appeal **

You may represent yourself or you may ask another person to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize________________________to pursue my appeal on my behalf.

____ ________________

Signature of Applicant (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: ___________________________________

City:__________________State:___Zip Code: ___________

Representative's Phone Number(s): Daytime: ( )____________ Evening: ( )_______________

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.)

______Medicaid Denial

______Medicaid Termination

______Special Enrollment Period (SEP) Denial

______Reinstatement Denial (Private Health Plan)

______Effective Data (a.k.a. "start date") Change Denial

______Voluntary Termination Date (a.k.a. "end date") Denial

______Advanced Premium Tax Credit (APTC) Denial or Calculation

______Cost-Sharing Reduction (CSR) Denial or Calculation

______Enrollment Denial (Private Health Plan through CoverME.gov)

______Insurance Mandate Exemption Denial

How do you want the agency's decision to be changed?

____

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____

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 _________
Note: If you select this option, and the result of your appeal is that you are determined eligible for less, 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 - Insurance Plan Information (if applicable)

Member's Name:_________________Insurance ID #:______________________

Health Insurance Company's Name: ____________________________________

Insurance Company's Mailing Address: __________________________________

City:____________________State:___Zip Code: _________

Insurance Company's Phone Number: (   ) ________________

Is the member's insurance plan provided by an employer? Yes___No___

Name of employer: ___________________

Employer's Phone Number: (   ) ______________

Is the employer's insurance plan self-funded? Yes*____ No ______

*If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review through the Bureau of Insurance. Please contact us for further information.

Section V – 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 an expedited basis.

Do you request an expedited review? Yes____No ________

For an expedited review, please call the Maine Consumer Assistance Center at **1-866-636-0355 (TTY: 711).**

Section VI – Request for a Hearing

** Complete this section, only if you would like to request a telephone or virtual hearing **

If the applicant or the authorized representative would like to discuss this case in a telephone or virtual conference, select "Yes" below.

Do you request a telephone or virtual hearing? Yes____No _______

*If yes, please provide your contact information and times available for the hearing:

Section VII- Mail Information

Please mail this Eligibility Appeals Request Form to:

**CoverME.gov Consumer Assistance Center P.O.
Box 616
Augusta, ME 04332-6626**