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: ____________________________

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 (Optional)

** 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: (   ) __________
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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 ________

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 – 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 ______
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