OAH Case No. _____ DHS Case No. _____
(Official Use Only) (Official Use Only)

DC HEALTH LINK
Get the facts. Get covered.

Appeal Request For Individual/Family Health Coverage

If you want to file an appeal for a program other than health coverage, such as TANF, SNAP, burial assistance, etc., you must call (202) 698-4133 or e-mail dc.oara@dc.gov.

Name(Appellant): _____ **Date:** ____/____/____

Telephone Number: (____) ____-_____

Address

_____

City: _____ State: _____ Zip: _____

Mailing Address (If Different)

_____

City: _____ State: _____ Zip: _____

Section 1 – I am requesting a hearing because I disagree with the following action(s):

Department of Human Service (select one)

a) ◯ Medicaid Denial

b) ◯ Medicaid Termination

Health Benefit Exchange Authority (check all that apply)

a) ☐ Special Enrollment Period (SEP) Denial

b) ☐ Reinstatement Denial (Private Health Plan)

c) ☐ Effective Date (a.k.a. "start date") Change Denial

d) ☐ Voluntary Termination Date (a.k.a. "end date") Denial

e) ☐ Premium Tax Credit (APTC) Denial or Calculation

f) ☐ Cost-Sharing Reduction (CSR) Denial or Calculation

g) ☐ Enrollment Denial (Private Health Plan through DC Health Link)

h) ☐ Insurance Mandate Exemption Denial

Section 2 – How do you want the agency's decision to be changed? 500 character limit.

Section 3 – List by name all others in your household whose benefits determination you are also appealing.
500 character limit

Section 4 – APTC/CSR Cases Only *[DO NOT USE THIS SECTION FOR A MEDICAID APPEAL]*

How much APTC were you approved for? $ _____ max/month ☐ (Please check if None)

How much CSR were you approved for? _____% ☐ (Please check if None)

☐ Check here if you want to receive APTC/CSR while your appeal is pending.

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 5 – Special Needs (OPTIONAL)

Check any special services that you would need to help you participate in the hearing. Approval is not guaranteed. The independent administrative law judge in your case decides whether to grant your request.

☐ I need an interpreter. What Language? _____

☐ I need to participate in the hearing by telephone for the following good reason(s). 300 character limit.

What telephone number should we call to contact you for the hearing? ( ) -

☐ I need another service. What type of service do you need? _____

EMERGENCY/EXPEDITED REQUEST

☐ Check here if your life, health, or ability to attain, maintain, or regain maximum function is currently in jeopardy because you have an immediate need for health services. ***If so, you must attach documentation (such as a doctor's note) explaining the immediate need. Failure to do so will result in your appeal being handled on a standard schedule.***

Section 6 – Contact Information

Attorney/Representative (if any):

Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: ( ) -

Person preparing request (if other than applicant):

Name:_____

Office/Center: _____

Telephone Number: ( ) -

I'm signing this appeal request under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that the submission of a false statement on this form is a crime punishable under D.C. Official Code § 22-2405. I also attest that I have permission from all of the people listed in Section 3 to submit an eligibility appeal request on their behalf.

Signature: _____ **Date:** ____/____/____

SEND BY U.S. MAIL, OR E-MAIL TO:

D.C. Health Benefit Exchange Authority
Eligibility Appeals Team
1225 Eye Street NW, Suite 400
Washington DC 20005

E-MAIL: OAH.Filing@dc.gov

PHONE: (855) 532-5465