SAMPLE

State of Maryland
Health Insurance Exchange

Person ID: 1111549463
Doc ID: 47851

Request for Fair Hearing

Fill out this form ONLY if you disagree with Maryland Health Connection's decision.

If you need help completing this form, call 1-855-642-8572 (TTY: 1-855-642-8573).

1. Tell us who you are. Fill in the blanks in this box and complete boxes 2-3. Please print clearly.

Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

Person ID: _____

2. What are the reasons you want a hearing? Please select one.

☐ I was not allowed to apply for coverage through Maryland Health Connection.

☐ My application was wrongly denied for (If you checked here, please select from below):

- ☐ Medicaid
- ☐ Maryland Children's Health Program Premium (MCHP Premium)
- ☐ Qualified Health Plan coverage through Maryland Health Connection
- ☐ Financial assistance with a Qualified Health Plan (Advanced Premium Tax Credit or Cost-sharing Reduction)

☐ I do not agree with the amount of my monthly premium tax subsidy (Advanced Premium Tax Credit) and/or the amount I have to pay out-of-pocket (cost-sharing reduction)

☐ Other _____

If you received a notice about this, what is the date on the notice? _____

Why do you want a hearing? Please tell us what happened. _____

3. FOR MEDICAID AND MCHP PREMIUM ELIGIBILITY

I understand that if I am currently receiving Medicaid/MCHP Premium, and I ask for a hearing within 10 days from the date of the notice, I can continue to receive those benefits while I wait for my hearing unless my benefits period ends. I also understand that I may have to pay back those benefits if I lose my appeal.

☐ Check here if you do **not** want benefits while you wait for your hearing.

Signature: Date:

4. FOR QUALIFIED HEALTH PLAN ELIGIBILITY

I understand if I ask for a hearing within 90 days from the date of the notice, I can still enroll in a qualified health plan and receive any financial assistance I am currently eligible for. The result of my appeal can change what coverage I qualify for. Depending on the result of my appeal, I may have to pay back any tax subsidies I receive to the Internal Revenue Service.

☐ Check here if you do **not** want benefits while you wait for your hearing.

Signature: Date:

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AUTHORIZED REPRESENTATIVE FORM

Section I: For Applicants/Recipients: If you want an Authorized Representative, complete questions 1-18. Submit this form via mail to: Maryland Health Connection, P.O. Box 2160, Manchester, CT 06045. You must include the cover sheet at the end of this letter with your documents.

An Authorized Representative is someone who you choose to act on your behalf with the Maryland Health Connection, like a family member or other trusted person. Some Authorized Representatives may have legal authority to act on your behalf.

1. Name of Authorized Representative (First Name, Middle Name, Last Name)
2. Address
3. Apartment or Suite Number
4. City
5. State
6. Zip Code
7. Phone Number
8. Organization Name (if applicable)
9. Your Name
10. Your Phone Number
11. Your Address
12. Apartment or Suite Number
13. City
14. State
15. ZIP Code
16. Your Maryland Health Connection Person ID# (if available)

By signing below, you allow the person named in question 1 to act for you on your behalf.

17. Your Signature
18. Date

Section II: For Legal Representatives of Applicants: If you are legally authorized to act on behalf of the applicant: 1. Complete this section by placing an "X" in the appropriate box below; 2. Fill out the questions above with the applicant's information; and 3. Submit proof(e.g. guardianship order or advance directive naming a health care agent) with this form.

A. Responsible Adult (Parent, guardian, healthcare surrogate, attorney, or other individual as defined in COMAR 10.01.04.12.)		**B.** Applicant's power of attorney	

Section III: For Certified Application Counselors, Navigators, Agents, and Brokers only. Complete this section if you are a certified application counselor, navigator, agent, or broker who is filling out this form for somebody else.

1. First Name, Middle Name, Last Name, & Suffix

2. Organization Name

3. ID Number(if applicable)

If you ever want to change your Authorized Representative or have any questions, call Maryland Health Connection at 1-855-642-8572 (TTY: 1-855-642-8573).