# Health Connector LogoAppeal Request for Massachusetts Health Connector for Business Employees

To appeal a determination that you were incorrectly determined ineligible for coverage through the Massachusetts Health Connector for Business, please complete this form. You have 90 days from the date of your eligibility determination to submit an appeal.

**EMPLOYEE NAME (Appellant): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TELEPHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address (If Different)**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**NAME OF EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER POINT OF CONTACT:**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TELEPHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address (If Different)**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Section 1** I am requesting an hearing because (check all that apply)

|  |
| --- |
| 1. \_\_\_ I applied to obtain coverage through the Massachusetts Health Connector for Business and have been determined ineligible. 2. \_\_\_ I applied to obtain coverage through the Massachusetts Health Connector for Business and did not receive a timely eligibility determination. |

**Section 2** Explain the reason for your appeal. Your explanation should include the reason why you believe the Massachusetts Health Connector for Business made a mistake. **You can attach additional pages if necessary.**

**Section 3 – Special Needs (OPTIONAL)** - Check any special services that you would need to help you participate in the hearing:

I need an interpreter

* + What Language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I need another accommodation or special service

* What type of accommodation do you need?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4 – Additional Information**

If you are including additional documents with this form to support your appeal, please only send copies – keep all original documents. Keep a copy of this completed appeal form for your records.

If your appeal is valid, it will be scheduled for a hearing. We will send you a notice telling you the date and time of the hearing at least 15 days in advance. Your hearing will be conducted by phone. If you do not reschedule or appear on time at the hearing without documented good cause, it will be dismissed.

**Section 5 – Representative Information**

**Attorney/Representative (if any): Person preparing request** **(if other than applicant**):

**Name:**  **Print name:**

**Address:**  **Office/Center:**

T**elephone #:**

**City, State, Zip:**

**Telephone #:**

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.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Send by U.S. Mail, E-mail, or Fax to:**

Massachusetts Health Connector Appeals Unit **FAX:** 617-933-3099

P.O. Box 960189 **PHONE:** 617-933-3096

Boston, MA 02196 **BUSINESS HOURS:** Monday–Friday, 8am–5pm