Appeal 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:	_____	_____
	_____	_____
	_____	_____

NAME OF EMPLOYER: _____

EMPLOYER POINT OF CONTACT:

NAME: _____

TELEPHONE #: _____

		Mailing Address (If Different)
ADDRESS:	_____	_____
	_____	_____
	_____	_____

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

a) ___ I applied to obtain coverage through the Massachusetts Health Connector for Business and have been determined ineligible.

b) ___ I applied to obtain coverage through the Massachusetts Health Connector for Business and did not receive a timely eligibility determination.

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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):

Name: _____
Address: _____
_____
City, State, Zip:_____
Telephone #: _____

Person preparing request (if other than applicant):

Print name: _____
Office/Center: _____
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
P.O. Box 960189
Boston, MA 02196

FAX: 617-933-3099
PHONE: 617-933-3096
BUSINESS HOURS: Monday–Friday, 8am–5pm

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