Appeals Request Form

Rev. 5/26/2017

You have a right to appeal if you think Your Health Idaho (YHI) made a mistake about you or your household eligibility to purchase health insurance through YHI through a special enrollment period or during open enrollment.

If you want to appeal your health care assistance (HCA) eligibility determination provided by DHW for Medicaid, CHIP, APTC, or CSR, please call 1-866-883-8620.

IMPORTANT: If you have a medical condition that requires an emergency or expedited hearing, do not use this form. Call YHI at 1-855-YH-IDAHO (1-855-944-3246) for assistance.

YHI Contact Information

Use the following contact methods to file an appeal.

If you need help to complete this form due to language or other challenges, contact YHI. There is no cost for assistance.

Call	Email	Mail	In-person
• 1-855-YHIdaho • (1-855-944-3246) • TTY (800) 377-3529	support@yourhealthidaho.org	Your Health Idaho PO Box 943 Boise, Idaho 83701	1010 West Jefferson Street Boise, Idaho 83702

If you want help from a certified Consumer Connector, go to **YourHealthIdaho.org > Enrollment Resources > Consumer Assistance Locator**. Select **Find Help Near You** for a list of certified Consumer Connectors and their locations.

Instructions

You have **thirty (30) days** from the date YHI mailed or emailed your Eligibility Notice to file an appeal. The date of the postmark on your appeal envelope, the date of your phone call request, or the date your email is received is considered the date you filed your appeal.

To file an appeal:

1. Complete the Appeal Request Form.
2. Submit the form to YHI with any contact method described in "YHI Contact Information."

Please keep a copy of all forms for your records.

The Your Health Idaho appeals process is in accordance with the Code of Federal Regulations, 45 C.F.R. §155.500 – §155.555.

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Claimant Information

The "Claimant" is the person requesting an appeal. This section should be filled out by the person requesting the appeal or by a parent/guardian, Authorized Representative, or YHI Consumer Connector.

First name	Middle name	Last name	Suffix
Date of birth (mm/dd/yyyy)		Phone number	
Email address			
Street address			Apt./Ste. #
City		State	ZIP code

Type of Appeal

Your Eligibility Notice explains whether you qualify to purchase insurance on YHI. Depending on your eligibility results, you may appeal for any of the following reasons (check as many boxes as you would like).

My appeal is because my eligibility to purchase or use health insurance on the exchange was denied for the following reason(s) on the following date(s):

Eligibility Type	Date of Denial or Notice
❑ Enrollment eligibility	
❑ Special Enrollment Period	
❑ Change of effective or termination date	
❑ Application of APTC/CSR	
❑ Other: _____	

Notice of Privacy Practices

Your Health Idaho is committed to maintaining the privacy and security of personally identifiable information. Your Health Idaho will use personally identifiable information only as permitted by Your Health Idaho's policies and as required by law.

More information about Your Health Idaho's privacy and security practices and your rights is available on Your Health Idaho's website at http://www.yourhealthidaho.org/privacy-policy/.

If you need help understanding this form in another language, or if you are disabled and need help to use this form, please contact Your Health Idaho. There is no cost for assistance.

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Explain the reason for your appeal

Your explanation should state the reason for your appeal, including relevant dates and account history. List any actions or communications you attempted to resolve your request prior to the appeal.

If your appeal request affects or impacts other members of your household, note their names and how they are impacted here. Add additional pages if needed.

Do you need assistance completing this appeals request? You can choose an authorized representative.

You can give a trusted person permission to communicate about this appeal with us, see your information, and act for you on matters related to this appeal, including getting information about your appeal and signing your appeal on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact YHI.

Name of authorized representative (First name, Middle name, Last name)

Phone number

Email address

Organization name

By signing below, you allow this person to sign your appeal, get official information about this appeal, and act for you on all future matters related to this appeal.

Claimant signature (required) Date (mm/dd/yyyy)

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Complete this section if you are a certified YHI Consumer Connector and are filing an appeal request on behalf of your consumer.

1. First Name, Last Name, & Suffix

2. Organization or Agency Name

3. State License Number (Agent/Broker Only)

4. Phone Number

5. Email Address

Read and sign below

The information in this section applies to all people signing below, including the Claimant.

I further understand that by completing, signing, and dating below, I authorize Your Health Idaho to disclose information collected based on my application and from other data sources that may have been used to make the eligibility determination. I understand that this information may be disclosed for use during the appeals process. The authorization is valid until the appeal is concluded or I notify Your Health Idaho otherwise.

I understand by completing, signing, and dating below, I authorize Your Health Idaho to disclose information in my eligibility record, based on the application I filled out, and from other data sources that may have been used to make the eligibility determination, to my authorized representative and other household members whose signatures are provided below. I understand I may request a copy of my eligibility record during the appeals process. The authorization is valid until the appeal is concluded or I notify you otherwise.

I am signing this form under penalty of perjury, which means I have provided true answers to all the questions I have answered to the best of my knowledge. I know that I may be subject to penalties under state and federal law if I provide false information.

I understand that I am not required to complete this form. I am voluntarily completing it to file an appeal request to Your Health Idaho.

Signature of Claimant only (or parent, guardian, or authorized representative, if applicable)
I understand that I am the primary contact for purposes of appealing these eligibility determinations.

Printed name of Claimant (Consumer Connector, parent/guardian, or authorized representative, if applicable)

Signature of Claimant (Consumer Connector, parent/guardian, or authorized representative, if applicable)	Date of signature (mm/dd/yyyy)

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Next steps

1. **Acknowledgment of Appeal Request:** We will send you a letter confirming receipt of your Appeals Request Form. This letter will provide you with an explanation of your health coverage while your appeal is pending. If there is a problem with your appeal request, such as missing information or the need for additional clarification, we will inform you by separate letter and permit you to correct the issue within a specific timeframe.
2. **Review of your information:** We will review your appeal request and any additional information you submit, along with the information we used to originally determine your eligibility. We may contact you to request additional information orto discuss your appeal. You have the right to review the information being used to resolve your appeal, including the information in your electronic account.
3. **Informal resolution:** We may be able to resolve your appeal informally. After reviewing all your information and discussing your appeal with you, as necessary, we'll send you an informal resolution decision. If you are satisfied with this informal resolution decision, we will implement the decision and close your appeal.
4. **Hearing:** If you are dissatisfied with the outcome of the informal resolution process, you may continue with your appeal and your right to an appeal hearing is preserved. You must notify Your Health Idaho within ten (10) days of the date of your informal resolution decision to schedule your appeal hearing. You will be provided with written notice of the date, time, location and format of the hearing no later than fifteen (15) days prior to the hearing date.

   The appeal hearing will be an evidentiary hearing in front of an appeal panel consisting of members of the Your Health Idaho Board of Directors (the "Appeal Panel"). You will be provided an opportunity to bring witnesses to testify, present evidence and argument, and cross-examine adverse witnesses. You also have the right to review all the information that the Appeal Panel will be considering for your appeal, including any information on your account.

   You may participate in the hearing by yourself or have someone participate in the hearing with you. This person can be a friend, relative, lawyer, your authorized representative (if you have one), or another individual. Your participation in the hearing may be done in person or by telephone

   The Appeal Panel will review and consider the information used to determine your eligibility as well as any additional relevant facts and evidence presented during the appeals process, including at the hearing. The Appeal Panel will then issue a final decision on your appeal which will be mailed to you.
5. **Submitting additional information:** You may submit additional information to support your appeal. Information you submit will be reviewed along with the information you submitted previously. You may submit additional information in advance of your appeal hearing by attaching and returning it with this form or by mailing it separately to:
   Your Health Idaho
   PO Box 943
   Boise, ID 83701
   If you mail additional information separately, include the complete contact information of Claimant (as it appears on this form), including name, date of birth, phone number, email address (optional), and address. Additional information may also be submitted at the time of the appeal hearing.
6. **Requesting an expedited appeal:** If you have an immediate need for health services and a delay could seriously jeopardize your health, you can ask for an expedited appeal by calling the Your Health Idaho Call Center at 1-855- YH-IDAHO (1-855-944-3246).
7. **Health coverage during your appeal:** You may be able to keep your eligibility for coverage while your appeal is pending. Our letter acknowledging receipt of your appeal will provide you with an explanation of your health coverage while your appeal is pending. If you are currently enrolled, you may be liable for any payments due to the carrier during the appeal processing time. If you request an adjusted effective date, you may be obligated to any outstanding payments due to the carrier during the appeal processing time.
8. **Language assistance services:** If you need language assistance in a language other than English, you have the right to get help and information in your language at no cost. Call the Your Health Idaho Call Center at 1-855-YH-IDAHO (1-855-944-3246) to access these language assistance services.
9. **Accessibility:** If you have a disability and need a reasonable accommodation, log into Your Health Idaho or call Your Health Idaho at 1- 855- YH-IDAHO (1-855-944-3246) to request accommodations. These accommodations are available and provided at no cost to you.
10. Where can I find more information? Email Your Health Idaho at support@yourhealthidaho.org, or call 1-855-YH-IDAHO (1-855-944-3246).