

APPOINT AN AUTHORIZED REPRESENTATIVE FOR MY APPEAL

You have the right to choose an authorized representative to help you with an eligibility appeal. This is a trusted person who has your permission to talk about your appeal with us, see your information, and act for you on matters related to your appeal, including getting information about you and signing your appeal request on your behalf. If you want to have an authorized representative, complete and submit this form.

Your information

1. Name (First name, Middle name, Last name)

2. Appeal Case ID # (if you have one)

APL-

3. Date of birth (mm/dd/yyyy)

Your authorized representative's information

4. Name (First name, Middle name, Last name)

5. Mailing address

6. Apartment or Suite number

7. City

8. State

9. ZIP code

10. Phone number with area code

11. Organization name (if applicable)

12. ID number (if applicable)

Your signature

By signing below, you allow the person named in box 4 to sign your appeal request, get official information about your appeal, and/or act for you on all future matters related to this appeal.

13. Signature

14. Date signed (mm/dd/yyyy)

Make a copy for your records and mail this completed form to:

Marketplace Appeals Center

P.O. Box 311

Pittston, PA 18640

You may also fax the form to our secure fax line at 1-877-369-0129.

To change or remove your authorized representative, or for more information, contact the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. Our

hours of operation are Monday through Friday, 7:30 a.m. to 11 p.m. Eastern Time (ET) and Saturday, 10 a.m. to 5:30 p.m. ET.

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. You can call 1-800-318-2596 (TTY: 1-855-889-4325) to get information on these services.

Accessibility

To request an auxiliary aid or service, you can:

- Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call: 1-844-716-3676.
- Send a fax to 1-844-530-3676.
- Send an email to: AltFormatRequest@cms.hhs.gov
- Send a letter to:

Centers for Medicare and Medicaid Services
Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
Baltimore, MD 21244-1850
Attn: CMS Alternate Format Team

Privacy Act Statement

The Marketplace protects the privacy and security of information about you that you have provided. To view the Privacy Act Statement, go to [HealthCare.gov/individual-privacy-act-statement/](https://www.healthcare.gov/individual-privacy-act-statement/). We're authorized to collect the information on this form and any supporting documentation, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111–152), implementing regulations in 45 CFR part 155, subpart F, and the Social Security Act. For more information about the privacy and security of your information, visit [HealthCare.gov/privacy/](https://www.healthcare.gov/privacy/).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1213. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.