Washington State Health Care Authority

Administrative Hearing Request

Use this form to request a hearing before a judge. Mail this form within 90 calendar days of the date on eligibility notice you disagree with. You may be able to keep Apple Health coverage during the hearing process if you request a hearing in less than 10 days.

IMPORTANT: If you have an immediate need for health services because the regular appeal process may take up to 90 days which could jeopardize your life, health or ability to maintain, or regain maximum function, please call one of the phone numbers on this form for more information.

Healthplanfinder Application ID #:	Date on Eligibility Notice:	Today's Date:

APPELLANT INFORMATION

Appellant's First Name	Last Name	Middle Initial	Date of Birth

Mailing Address	City	ZIP Code	Daytime Telephone Number ( )

Email Address	Name of Employer/Company (if this employer provides your health insurance)	Employer Phone Number ( )

What is the best way to contact you? ☐ Email ☐ Telephone ☐ Mail

REASON FOR YOUR ADMINISTRATIVE HEARING

☐ **Washington Apple Health (e.g. Medicaid, CHIP) Questions? 1-800-562-3022**

☐ I would like to keep my WA Apple Health coverage during the hearing process. You must send this form to the Health Care Authority within 10 days of receiving the notice or before your coverage ends, whichever is later.

Mail to: Health Care Authority
PO Box 45504
Olympia, WA 98504-5504

☐ **Health Insurance Premium Tax Credit, Cost Sharing, Special Enrollment Questions? 1-855-859-2512**

Mail to: WAHBE Appeals
PO Box 1757
Olympia, WA 98504-1757
FAX to: 360-841-7653

Please explain why you think our decision was wrong (so the judge knows why you want a hearing):

PLEASE COMPLETE AND SIGN THE OTHER SIDE → → →

HOW CAN WE HELP?
Hearings are in English, unless you request an interpreter or other accommodations.

Do you want your notices in a language other than English? ☐ Yes ☐ No	If yes, what language?
Do you want an interpreter at no cost? ☐ Yes ☐ No Friends or family members may not act as an interpreter for you at the hearing.	If yes, what language?
Do you need other accommodations or help because of a disability? ☐ Yes ☐ No	
If yes, please describe what you need:	

TRIBAL AFFILIATION

Are you a member of a federally recognized tribe? ☐ Yes ☐ No	If yes, what tribe?

REPRESENTATIVE (NOT REQUIRED)

Representative Last Name	First Name	Telephone Number ( )	
Representative Email		Alternate Phone Number ( )	
Address	City	State	Zip

Representative's relationship to the appellant. (Check all that apply)

- ☐ Attorney/Legal Counsel
- ☐ Employer
- ☐ Family member or friend
- ☐ Tribal Representative
- ☐ Insurance Agent or Broker
- ☐ Legal Guardian/Power of Attorney
- ☐ Legal consultant or advocate (not an attorney)
- ☐ Other: _____

SIGNATURE (REQUIRED)

My signature below is my request for a hearing before a judge. I disagree with the decision about my eligibility for tax credits, Apple Health or Special Enrollment made by the Washington Healthplanfinder. The information provided in this form is true and correct, to the best of my knowledge. I understand that this request for a hearing may be forwarded to the entity with the authority to handle my appeal.

Primary Applicant's signature **X**	Date