You can get this information in large print. Call **1-877-623-6765** from Monday to Friday, 8:00 a.m. to 6:00 p.m. **TTY: 1-877-623-7773**

[Recipient Name]
[Organization Name]
[Address Line 1]
[Address Line 2]
[City], [State] [Zip]

Date : [Notice Date]
Notice ID : [Notice ID]
Member ID : [Member ID]

Notice Name : [Notice Name]

Attn: [ARD Name]

Re: Notice sent to [Primary Recipient Name]

Dear [Primary Recipient Name],

We have determined that the people listed below do not qualify for health insurance coverage through the Massachusetts Health Connector.

- [Household Member Name] Member ID: [Member ID] Date of Birth: [DOB]
  - Does not qualify because: [Health Connector Denial Reason] See the law at Regulation Citation].

How you can send us information

If your information has changed, please let the Health Connector know as soon as possible. This includes any changes to your income, address, phone number, family size, job, or health insurance.

To let us know about a change, call the Health Connector at 1-877-623-6765 or TTY: 1-877-623-7773.

If you think the immigration status is wrong

Our decision is based on information we received from the Department of Homeland Security (DHS) about the immigration status of the person listed in this notice. To find out how DHS reported the status of the individual(s) listed in this notice or to dispute DHS' decision, call DHS at 1-800-375-5283 or TDD: 1-800-767-1833 if you are deaf, hard of hearing or speech disabled or visit http://www.dhs.gov and search for the "SAVE program". If you dispute DHS' decision and DHS updates the individual's immigration status, we can re-evaluate the individual's case to see if he or she qualifies for more benefits.

You may qualify for coverage through MassHealth

Comment [NR1]: Dynamic, based on number of members in house hold

Comment [NR2]: Regulation Citation – refer denial code

Comment [NR3]: Dynamic if verify lawful presence denial

MassHealth will also check to see if the people listed above qualify for health coverage through MassHealth, the Health Safety Net (HSN), or Children's Medical Security Plan (CMSP).

They will get another letter to let them know if they qualify for any of these programs. MassHealth will contact them if they need more information to make a decision. If you have any questions, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Comment [BVJ4]: Include fragment for individuals who applied for a subsidy.

If you do not agree with our decision

You may appeal to the Health Connector if you do not agree with our decision. Please use the ***Hearing Request Form*** that came with this letter.

If you have questions

Call us at 1-877-MA ENROLL (1-877-623-6765) or TTY: 1-877-623-7773, Monday through Friday, 8:00 a.m. to 6:00 p.m.

Thank you,

Massachusetts Health Connector

«SeqN

If you think our decision is wrong

You may use this **Hearing Request Form** to appeal the Health Connector's decision.

Your Right to Appeal
If you disagree with the action taken by the Massachusetts Health Connector, you have the right to appeal and ask for a hearing before an impartial hearing officer. You can also request a hearing if no one acted on your request in a reasonable time.

How to Appeal
To ask for a hearing, fill out this form and send it to the **Massachusetts Health Connector Appeals Unit, P.O. Box 960189 Boston, MA 02196** or fax it to **1-617-933-3099**. For information about appealing by phone, please call customer service at 1-877-MA-ENROLL (1-877-623-6765). Please keep a copy of your request for hearing form for your information. We must receive your completed, signed request within 30 days from the date you received the notice of our action. If you did not receive a written notice of the action to be taken, or the Health Connector did not take an action on your application, you must send your request 120 days from the date of the intended action.

If You Are Now Getting Benefits
You may be eligible to keep your benefits while your appeal is decided. If you keep your benefits, and then lose your appeal, you may have to pay back the benefits you received during your appeal. If you do not keep your benefits, and then you win your appeal, we will restore your benefits. Please check one of the lines in the "If You Are Now Getting Benefits" section of the form.

Date of Hearing
At least 15 days before the hearing, we will send you a notice telling you the date and time of the hearing. Your hearing will be conducted by phone, but you may request an in-person hearing for good cause by calling the Health Connector Appeals Unit at 1-617-933-3096 (TTY: 1-877-623-7773). If you need the hearing quickly to avoid harm to your health, please check the line on the back of the form to request an expedited hearing. We will determine if you qualify for an expedited hearing.

Your Right to Be Helped at the Hearing
At the hearing, you may have a lawyer or other person represent you, or you may represent yourself. We will not pay for anyone to represent you. You may contact a local legal aid service or community agency to see if you can receive advice or representation at no cost. A hearing request can also be filed on your behalf by an individual authorized to act on your behalf. If someone other than a lawyer is acting on your behalf, please attach a copy of the document authorizing someone to file a hearing request on your behalf (for example, Power of Attorney, Guardian, or Authorized Representative).

If You Need an Interpreter, Assistive Device, or Other Accommodation
If you do not understand English or if you are hearing or sight impaired, we will provide an interpreter or assistive device at the hearing at no cost to you. We will also make other reasonable accommodations a person with a disability may need to participate in the hearing. Please tell us what you need in the "Other Information" section of the form.

Your Right to Review Your Case File
You or your representative can review your case file before the hearing. If you wish to review your case file, please call the Health Connector Appeals Unit at 1-617-933-3096 (TTY: 1-877-623-7773).

Your Right to Ask to Subpoena Witnesses and Your Right to Question
You or your representative may write to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and ask questions of witnesses at the hearing. The hearing officer will make a decision based on all evidence presented at the hearing.

Impact on Other Household Members
Please note that an appeal decision for one household member may result in a change in eligibility for other household members.

Hearing Request Form

[Primary Recipient Name]

Notice ID: [Notice ID] **Notice Date:** [Notice Date]

First Name	Middle Initial	Last Name	
Mailing address	City	State	Zip
	[Member ID]		
Phone number	Member ID	Date of Birth	

Reason for your appeal (Circle any reason(s) that may apply)

Income	Citizenship/Immigration status	Access to other insurance
Family size	Residency	Incarceration status

Other:____

Please explain why you are appealing. Attach any documents that support your reason.

____
____

Keeping benefits during appeal (Check one if you are now getting benefits)
__ I wish to accept, during the appeal process, the proposed change in my coverage in the notice I received. (If you check here and win your appeal, we will restore your original level of benefits)
__ I wish to keep getting the same level of benefits during the appeal process that I was receiving before. (If you check here and lose your appeal, you may have to pay back the cost of the benefits you received during your appeal)

Other information Please check all that may apply. If you need an interpreter, assistive device, or other accommodation, we will provide for you at the hearing. Please describe your needs below.
__ I need an interpreter. My language is____
__ I need an assistive device to communicate at a hearing. (Describe device)____________________
__ I need another accommodation for a disability (Describe accommodation)____________________
__ I need an expedited hearing to avoid harm to my health, because ___________________________

Appeal Representative, if any

First Name	Last Name			Title
Mailing Address	City	State	Zip code	Phone Number

Signature The information on this form is true and accurate, to the best of my knowledge. I authorize the Health Connector to provide me and, if I have one, my representative or translator with my individual information, including federal and state tax information used in the determination of my eligibility, for purposes of this appeal process.

Signature (Sign)	Date	First and Last Name (Print)

If this is signed by someone other than an appellant 18 years of age or older who has authority to file, please attach a copy of your authority to file the appeal on behalf of the appellant (for example, a copy of your authorized representative form, power of attorney document, or evidence of court appointment as a personal representative).

[FPL]%

Important! This has important information about your health insurance. If you want the information translated into your own language, call **1-877-623-6765**.

¡Importante! Esto tiene información importante sobre su seguro de salud. Si usted quiere la información traducida a su propio idioma, llame al **1-877-623-6765**.

Spanish

សំខាន់! ក្នុងនេះមានព័ត៌មានសំខាន់អំពី ធានារ៉ាប់រងសុខភាពរបស់អ្នក។ ប្រសិនបើអ្នកចង់បានព័ត៌មាននេះបកប្រែជាភាសារបស់ អ្នក សូមទូរស័ព្ទមកលេខ **1-877-623-6765**។

Cambodian

重要提示：該文件載有關於您的醫療保險的重要資訊。如果您想要將相關資訊翻譯為您的母語，請致電 1-877-623-6765。

Traditional Chinese (Cantonese)

重要提示：该文件载有关于您的医疗保险的重要信息。如果您想要将相关信息翻译为您的母语，请致电 **1-877-623-6765**。

Simplified Chinese (Mandarin)

Enpòtan! Sa a gen enfòmasyon enpòtan ou asirans sante ou. Si w vle nou tradwi enfòmasyon an nan pwòp lang ou rele **1-877-623-6765**.

Haitian Creole

ສິ່ງສຳຄັນ! ນີ້ມີຂໍ້ມູນທສຳຄັນກ່ຽວກັບການປະກັນໄພສຸຂະພາບຂອງທ່ານ. ຖ້າຫາກທ່ານຕ້ອງການຂໍ້ມູນຂ່າວສານເຂົ້າໃນການແປພາສາໄທຫາ **1-877-623-6765** ຂອງຕົນເອງຂອງທ່ານ.

Laotian

Importante! Neste pacote há informações importantes sobre o seu seguro-saúde. Se quiser que as informações sejam traduzidas para o seu idioma, ligue para **1-877-623-6765**.

Brazilian Portuguese

Importante! Contém informações importantes sobre o seu seguro de saúde. Se desejar a tradução das informações para a sua língua, contacte-nos pelo telefone **1-877-623-6765**.

European Portuguese

Важная информация! Здесь содержится важная информация о Вашем медицинском страховании. Если Вы хотите, чтобы информация была переведена на Ваш родной язык, позвоните по номеру: **1-877-623-6765**.

Russian

Lưu ý quan trọng! Đây là thông tin quan trọng về bảo hiểm y tế của quý vị. Nếu quý vị muốn có bản dịch thông tin này bằng ngôn ngữ của quý vị, hãy gọi số **1-877-623-6765**.

Vietnamese