BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

WILLIAM D. GRUHN
Chief
Consumer Protection Division

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

Writer's Direct Dial No.

Dear Consumer,

Thank you for contacting the Health Education and Advocacy Unit regarding your complaint against Maryland Health Connection.

Enclosed please find a complaint form and an Authorized Representative Form. In order to begin working on your complaint, we will need the following:

- ❑ Completed complaint form;
- ❑ Copies of any notices or other correspondence that you have received *(please do not send us original documents)*;
- ❑ If you are appealing an Advanced Premium Tax Credit or Cost-Sharing Reductions determination – Copies of your financial documents (income information for everyone in the family – paystubs, W-2 forms, wage and tax statements)*(please do not send us original documents)*; and
- ❑ Signed and dated Authorized Representative form. (This form is necessary to allow us to act on your behalf).

Failure to return a signed Authorized Representative form may result in closure of your case.

Please return the above-referenced materials to our office via mail, email or fax:

Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Fax: 410-576-6571
heau@oag.state.md.us

Once we have received your materials your case will be assigned to a member of our staff on a first come, first served basis. You will be contacted by your assigned mediator or ombudsman once your case is assigned.

Please review the enclosed information explaining the complaint process and our procedures. If you have any questions, or wish to check on the status of your complaint, please do not hesitate to contact us at (410) 528-1840 or toll free at (877) 261-8807. Our hotline is open Monday through Friday from 9:00 a.m. until 4:30 p.m.

Thank you,

Health Education and Advocacy Unit

What is the Health Education and Advocacy Unit (HEAU)?

The Health Education and Advocacy Unit of the Consumer Protection Division of the Attorney General's Office is a unit that handles consumer complaints involving a variety of issues in the healthcare marketplace. Typical complaints include medical billing and reimbursement problems, medical records access issues, medical equipment sales and warranty issues, and health insurance disputes. The Unit uses the process of mediation to attempt to resolve these consumer complaints. If you file a complaint that involves an issue that we cannot handle, we will attempt to refer your complaint to a more appropriate agency.

What is Mediation?

The process of mediation is one in which a third-party (mediator) works with parties in a dispute to try to bring about a cooperative settlement. We will gather information about your dispute and work toward a cooperative resolution of the problem.

Three keys to successful mediation are cooperation, information, and communication. In order for mediation to work, the parties to the dispute must be willing to try to resolve the problem. We find in most cases that businesses and consumers work hard to both avoid problems and to resolve problems when they arise. We will need information from both you and the business involved in the complaint.

The primary source of information from you will be the complaint form and the documents you provide about your complaint. We may call or write to you for additional information. It is important that you make clear in your complaint what you would like to see as a result of filing your complaint. We will also contact the businesses involved to seek information about the dispute and ask what offer the business would propose to resolve the problem. Most importantly, we will attempt to re-establish lines of communication between you and the business which will often lead to a resolution of the problem.

What are the Limits of Mediation?

The HEAU can help you file your appeal and can negotiate with Maryland Health Connection on your behalf prior to your hearing. Unfortunately, if your case proceeds to a hearing, the **HEAU CANNOT REPRESENT YOU IN THE HEARING OR IN COURT OR OTHERWISE ACT AS AN ATTORNEY**. If our mediation efforts are not successful, we will close your complaint file.

Is My Complaint Public Information?

We are required to make available some information from your complaint file upon request. However, to the extent that disclosure could reveal medical, psychological, or financial information, that information will not be released.

OFFICE OF THE ATTORNEY GENERAL, CONSUMER PROTECTION DIVISION
HEALTH EDUCATION AND ADVOCACY UNIT
COMPLAINT FORM
Request for Assistance with an Appeal of Maryland Health Connection Denial

This form is to be used by any person who requests help in filing an appeal of a Maryland Health Connection decision denying Qualified Health Plan coverage or denying Advanced Premium Tax Credits or Cost-Sharing Reductions.

IMPORTANT: You only have 90 days from the date of the Maryland Health Connection notice to ask for a hearing. It is very important to provide us with your documents as soon as possible.

Medicaid Denials: The HEAU is unable to help consumers with Medicaid Eligibility denials.

INFORMATION ABOUT YOU

First Name:_____ Middle Initial:_____ Last Name:_____

Date of Birth:_____ Email Address:_____

Address Line 1:_____

Address Line 2:_____

City:_____ State:_____ Zip:_____ County:_____

Daytime Telephone Number: _____ Alternate Number: _____

Maryland Health Connection ID:_____

OTHER FAMILY MEMBERS LISTED ON THE APPLICATION FOR COVERAGE

Name:_____ Date of Birth:_____ Relationship:_____

Name:_____ Date of Birth:_____ Relationship:_____

Name:_____ Date of Birth:_____ Relationship:_____

Attach additional sheets if needed.

WHY DO YOU WANT A HEARING?

_____ ☐ I was not allowed to apply for coverage through Maryland Health Connection.

_____ ☐ I was told I did not qualify for an Advanced Premium Tax Credit.

_____ ☐ I was told I did not qualify for Cost-Sharing Reductions.

_____ ☐ I do not agree with the amount of my Advanced Premium Tax Credit.

_____ ☐ Other:

DID YOU RECEIVE A NOTICE FROM MARYLAND HEALTH CONNECTION?

Yes ☐ No ☐ Date of Notice:_____

What were the reason(s) listed for your denial?

Why do you disagree with the reason(s) listed?

ADDITIONAL INFORMATION

Have you spoken with anyone at Maryland Health Connection or to a Navigator? Yes ☐ No ☐

Navigator ☐ Call Center Representative ☐ Unknown ☐

Name of Person: _____

What have they told you about your complaint?

Is there additional information you would like to add?

How did you hear about us?

HAVE YOU FILED AN APPEAL ALREADY?

Yes ☐ No ☐ Date:_____

How did you file your appeal? Phone ☐ Email ☐

Mailed to: Maryland Health Connection ☐ Office of Administrative Hearings ☐

DID YOU ENROLL IN A HEALTH INSURANCE PLAN?

Plan Name _____ Type of Plan _____

Membership Number/ID Number _____

IMPORTANT INFORMATION

1. **The HEAU cannot help you with your appeal without a signed Authorized Representative Form**. Please fill out Sections I, IV and V, and below Section V on the attached Authorized Representative Form and return the form to us.

2. If you are appealing an Advanced Premium Tax Credit or Cost-Sharing Reductions determination we will need to have your financial information to help you. Please send in any financial information you have to support your claim. *Please do not send us any original documents.*

3. If you are appealing an Advanced Premium Tax Credit or Cost-Sharing Reductions determination we will need to obtain the IRS information that Maryland Health Connection used to make their decision. In order to receive that information we need your permission. Please sign the attached Federal Tax Information (FTI) Form and return the form to us. *Note: This form is not yet finalized and approved by the IRS. We will send you this form once it is approved.*

4. The HEAU can help you file your appeal and can negotiate with Maryland Health Connection on your behalf prior to your hearing. Unfortunately, if your case proceeds to a hearing, the HEAU cannot represent you at that hearing.

5. A copy of the complaint form and any documents you provide us may be sent to Maryland Health Connection and their authorized agents. If your complaint should be referred to another State or Federal agency (ex. Maryland Insurance Administration, Department of Health and Mental Hygiene) we will forward your complaint to that agency. By filing a complaint with our office you are authorizing us to forward your complaint to another State or Federal agency, if appropriate.

6. Complaints submitted to our office become matters of public record; however, all or part of the complaint may remain confidential as required or permitted by Maryland's public records law. For example, in healthcare-related complaints filed with our office, medical or psychological information about an individual will not be disclosed to the public. Financial information will not be disclosed.

SIGNATURE

Complainant Signature:_____ Today's Date:_____

Submit this completed Complaint Form, Authorized Representative Form, MHC Notice, Federal Tax Information Form (*this form has not been finalized),* financial information and any other supporting documents via mail, fax or email to:

Office of the Attorney General, Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Fax: 410-576-6571
Email: heau@oag.state.md.us

Please DO NOT send us original supporting documents.

You only have 90 days from the date of the Maryland Health Connection notice to ask for a hearing. It is very important to provide us your documents as soon as possible.

maryland health connection℠

MARYLAND HEALTH BENEFIT EXCHANGE
RELEASE OF INFORMATION AUTHORIZATION FORM

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of my Personally Identifiable Information related to my application for health insurance, Advanced Payment Tax Credits, Cost Reduction Sharing and/or other benefits provided to the Maryland Health Benefit Exchange.

Print Name of Individual

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY Maryland Health Connection	NAME OF PERSON/ORGANIZATION/FACILITY Health Education and Advocacy Unit
ADDRESS PO Box 857	ADDRESS 200 St. Paul Place, 16th Floor
CITY/STATE Lanham, MD 20703	CITY/STATE Baltimore, MD 21202

III. The purpose or need for this disclosure is:

☐ Personal Use ☐ Attorney ☐ Disability ☐ Other *(Specify)* _____

☑ Insurance ☐ School

IV. The information to be disclosed from my enrollment application(s): *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify)* _____

☐ Entire Record

☐ Written correspondence generated by MHBE related to my application.

If you would like any following sensitive information not to be disclosed, please list:

_____

V. I understand that I may revoke this authorization in writing submitted at any time to the MHBE Custodian of Records, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

I understand that MHBE will not condition eligibility for cost saving reductions, APTC or other benefits on my providing this authorization. This authorization extends only to the records generated by MHBE and does not include records created by third parties. It is my responsibility to request records directly from the generating party.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected under Maryland law and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF INDIVIDUAL OR AUTHORIZED REPRESENTATIVE *(State relationship to individual)*	DATE
SIGNATURE OF WITNESS *(If signature of individual is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used or re-disclosed by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a State agency under false pretenses shall be guilty of a misdemeanor. **The below information must be completed in its entirety in order for MHBE to release the requested information.**

NAME *(Last, First, MI)*

Last 5 digits of Record Holder's Social Security Number **OR** MHBE Personal Identification Number (PIN)

ADDRESS

DATE OF BIRTH (mm/dd/yyyy)

STREET CITY, STATE, AND ZIP CODE