Qualified Health Plan Enrollee Experience Survey
REQUEST FOR APPEAL

Organization Name: _____ Date Submitted: _____

Address: _____

Primary Contact: _____ Title: _____

Telephone: _____ E-mail: _____

Please provide new or additional information in the Response Section(s) below for each Criterion Not Met that is being appealed.

Criterion Not Met:
New or Additional Information:
Justification for Exclusion from Participation Form:
Criterion Not Met:
New or Additional Information:
Justification for Exclusion from Participation Form: