**Qualified Health Plan Enrollee Experience Survey**

**2020 Request for Appeal Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Organization Name: |  | Date Submitted: |  |
| Address: |  |
| Primary Contact: |  | Title: |  |
| Telephone: |  | Email: |  |

Please provide *new* or *additional information* in the response section(s) below for each *Criterion Not Met* that is being appealed and a justification for the initial exclusion of this information from your organization’s 2020 QHP Enrollee Survey Vendor Participation Form.

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

*Submit the appeal form to the Project Team via email at the following address:* QHPSurveyVendor@bah.com. *Please include the following in the subject line: “[Vendor Name] 2020 Vendor Appeal Form”.*