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".*