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: <u>QHPSurveyVendor@bah.com</u>. Please include the following in the subject line: "[Vendor Name] 2020 Vendor Appeal Form".

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1249. The time required to complete this information collection is estimated to average 2 hours per response. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.