Other formats and languages
You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Explore Health at explorehealth@oha.oregon.gov or 855-268-3767 (voice). We accept all relay calls.

Explore Health Letter of Explanation

If you received a notice from Explore Health indicating you need to send documents to verify your application information **and** you do not have any of the documents listed on the notice, you may submit a written letter to Explore Health to explain why you do not have the documents requested. Please use this form to provide your written explanation for any of the missing information below:

☐ Public medical program(s) (i.e, Oregon Health Plan (OHP), Medicare, or VA benefits) status

☐ Annual income

☐ Other (e.g., confirming enrollment status as American Indian or Alaska Native, confirming a life event, death)

Complete Step 1 and only each Appendix of this form for the information you are missing. Please include all relevant information necessary to support your explanation to confirm coverage status.

Step 1: Contact information

Provide the contact information for the Primary Applicant on your Explore Health application.

Application ID: _____

You can find this number at the top of the letter you got from Explore Health or in your online account.

Name (First, Middle, Last): _____

Date of Birth (mm/dd/yyyy): _____

Email: _____

Appendix A: Public medical program(s)

Complete this section if you need to verify your enrollment status in a public medical program.

Do you currently have Medicare Part B (Medical Insurance), but are not eligible for premium-free Medicare Part A (Hospital Insurance)? ☐ Yes ☐ No

If yes, what date did your Part B start (mm/dd/yyyy)? _____

Did you previously have Medicare Part A coverage? ☐ Yes ☐ No

If yes, what date did your Part A coverage end (mm/dd/yyyy)? _____

Did you have Medicare because of a disability, but are no longer enrolled? ☐ Yes ☐ No

If yes, what date did your Medicare coverage end (mm/dd/yyyy)? _____

Did you ever have health coverage through TRICARE? ☐ Yes ☐ No

If yes, what date did your TRICARE end (mm/dd/yyyy)? _____

Did you ever have health coverage through the Peace Corps? ☐ Yes ☐ No

If yes, what date did your coverage end (mm/dd/yyyy)? _____

Did you ever have health coverage through the Department of Veteran Affairs? ☐ Yes ☐ No

If yes, what date did your coverage end (mm/dd/yyyy)? _____

Include and attach as many pages as necessary, and explain why you cannot send the requested documents confirming your coverage status below:

Appendix B: Annual Income

Complete this section if you need to verify your annual household income.

Important note: The annual income you enter must match the income you reported on your Explore Health application. If it does not, please update your Explore Health application.

Remember: It is important to enter an accurate income estimate on your Explore Health application. If the income you entered on your application is less than the income you report on your taxes at the end of the year, you may have to pay back some or all the Advance Premium Tax Credits (APTCs) you used when you file your taxes. If your estimated income changes during the year, update your application with this information right away.

Estimated Household Income (Amount): $

Year (e.g., 2027):

Include and attach as many pages as necessary, and explain why you cannot send the requested documents confirming your income below:

Appendix C: Other

Complete this section if you have received any other type of Data Matching Issue (DMI) (e.g., confirming enrollment status as American Indian or Alaska Native, confirming a life event, death) and need to explain why you cannot provide the requested documentation.

Include and attach as many pages as necessary, and explain why you cannot send the requested documents below:

- I understand that changes in the number of people in my household, address, income or other details may affect my or my household's eligibility for specific benefits. I understand that I have 30 days to notify Explore Health if anything on my application information changes.

- I understand the answers on this form are only used to see if I can get coverage or financial help. I acknowledge Explore Health will verify my answers in the Explore Health databases and in federal or state databases. I agree that my information may be used to check the details on my application. I confirm that I have permission from everyone included on this application to use their information for this purpose.

- I sign this form under penalty of perjury. That means, to the best of my knowledge, I gave true, correct and complete answers to all the questions on this form. I know that under federal law if I provide false and/or untrue information I may be subject to penalties and/or be liable for overpayments.

Signature of Primary Applicant: _____

Date Signed (mm/dd/yyyy): _____

Printed Name: _____

Step 2: Submit your completed form in one of the following ways

Please include all materials and associated documentation within one PDF if you are uploading to your account. If sending by USPS, please include all materials and associated documentation within one envelope and send via certified mail.

Please do not send originals, no documents are kept longer than 60 days and will be destroyed after being uploaded into the Applicant Portal.

Online	Mail	Fax
For faster processing, upload this document in your online account at ExploreHealthOR.gov.	c/o Documents Explore Health PO Box 191 Salem, OR 97308	888-705-8691

Explore Health: Oregon's Health Insurance Marketplace
PO Box 191
Salem, OR 97308
855 268 3767 (Relay calls welcome)
ExploreHealthOR.gov