



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
P.O. Box 11729  
Albany, NY 12211

## **NOTICE OF DISMISSAL – FAILURE TO APPEAR**

Notice Date: July 18, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000006587

[REDACTED]

Dear [REDACTED],

On January 23, 2016, NY State of Health (NYSOH) issued a notice of enrollment confirmation, stating that your enrollment in your Medicaid Managed Care plan started as of March 1, 2016. You appealed this notice.

On April 22, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for May 31, 2016 at 3:00 PM.

On May 31, 2016, a Hearing Officer called you on the telephone number that you provided to NYSOH. You answered the phone and stated that you did not know that the hearing was scheduled for that day, and that you could not speak to the Hearing Officer because you were on your way to an appointment. You requested that the hearing be rescheduled.

On May 31, 2016, NYSOH issued a second Notice of Hearing to advise you that the hearing you requested had been rescheduled for July 14, 2016 at 9:00 AM.

On July 14, 2016, a Hearing Officer placed three calls to the telephone number that you provided to NYSOH, at 9:00 AM, 9:15 AM, and 9:30 AM, but was unable to reach you.

Since you did not appear for your hearing as scheduled, we are dismissing your appeal.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-622-4886).

## **How does this Dismissal Affect My Eligibility?**

The Appeals Unit of NYSOH will not review your appeal at this time.

## **If You Think Your Appeal Should Not Be Dismissed**

If you think your appeal should not be dismissed, you can ask us to vacate (cancel) this dismissal. You must ask us, in writing, within 30 days of the date on this notice. In that writing, you must explain why you did not appear for your hearing as scheduled.

NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

## **Appeal Identification Number**

When communicating with NYSOH about this appeal, please refer to both the Appeal Identification Number and the Account ID at the top of this notice.

## **How to Contact NYSOH**

You can contact NYSOH in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-622-4886).

## **Legal Authority**

We are sending you this notice in accordance with 45 Code of Federal Regulations § 155.530.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-622-4886).

**A Copy of this Notice of Dismissal Has Been Provided To:**



If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-622-4886).