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

NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: June 8, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000006610

[redacted]

Dear [redacted],

On January 9, 2016 an "Authorized Representative Designation Form," designating [redacted] as your authorized representative for all matters related to your account, was faxed to New York State of Health (NYSOH).

On January 29, 2016 NYSOH issued an enrollment notice confirming that you were enrolled in Healthfirst (Medicaid) with a plan enrollment start date of March 1, 2016. An appeal was requested insofar as the plan enrollment start date of that plan.

On April 27, 2016 NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for June 3, 2016 at 3:00 pm. The notice stated that the Hearing Officer, from the NYSOH Appeals Unit, would contact you using the number in your NYSOH account. The notice directed you to contact NYSOH if you would like to change the telephone number.

On June 3, 2016, a Hearing Officer from the NYSOH Appeals Unit attempted to contact you using the telephone number listed on the Notice of Hearing and the telephone numbers listed on the Authorized Representative Designation Form between 3:00 pm and 3:30 pm. However, there was no answer. Accordingly, we were unable to reach you.

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

How does this Dismissal Affect My Eligibility?

The Appeals Unit of NY State of Health 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 after the date on this notice. In that writing, explain why you did not appear for your hearing as scheduled.

The 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, the Marketplace will tell you in writing.

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

Appeal Identification Number

When communicating with the Marketplace about this appeal, please refer to the Appeal Identification Number at the top of this notice.

How to Contact the Marketplace

You can contact us 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

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulations 45 CFR § 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:

[redacted]

[redacted]

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