



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

## NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: September 20, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008022

[REDACTED]

Dear [REDACTED],

On March 19, 2016, NY State of Health (NYSOH) issued a notice of enrollment confirming that your Essential Plan coverage and your son's Medicaid Managed Care (MMC) plan coverage would each begin effective May 1, 2016. You appealed this notification insofar as you did not agree with the coverage start date of either your Essential Plan or your son's MMC plan.

On August 16, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for September 15, 2016, at 9:00 a.m.

On September 15, 2016, a Hearing Officer from the NYSOH Appeals Unit called you. You answered that call and stated that you were not prepared to go forward with the hearing and requested to adjourn the hearing to September 16, 2016 at 9:00 a.m. The Hearing Officer granted your request for an adjournment, but cautioned you that if you did not appear for the hearing on September 16, 2016 at 9:00 a.m., your appeal would be dismissed.

On September 16, 2016, a Hearing Officer placed three calls to the telephone number that you provided to NYSOH, at 9:00 a.m., 9:17 a.m., and 9:30 a.m., 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 after 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

## **Legal Authority**

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

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



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