



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

## NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: September 26, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008184

[REDACTED]

Dear [REDACTED],

On February 19, 2016, New York State of Health (NYSOH) issued an enrollment notice confirming that you and your spouse were enrolled in an Essential Plan 2 health plan, with a plan enrollment start date of April 1, 2016.

Also on February 19, 2016, NYSOH issued a disenrollment notice, in relevant part, that your children's Child Health Plus (MVP Health Plan, Inc.) would end March 31, 2016.

On March 22, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as the plan enrollment start date of you and your spouse's Essential Plan, and your children being disenrolled from their Child Health Plus plan, effective March 31, 2016.

On August 22, 2016, NYSOH issued a Notice of Telephone Hearing advising you that the hearing you requested was scheduled for September 22, 2016 at 1:00 pm. The notice stated that the Hearing Officer from NYSOH Appeals Unit would be contacting you at [REDACTED]

On September 22, 2016, a Hearing Officer attempted to call you at the telephone number that you provided to NYSOH between 1:00 pm and 1:30 pm. However, the telephone number you provided to the NYSOH, as stated in the Notice of Telephone Hearing, was not in service. Please contact NYSOH immediately and update your account.

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).

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 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 provide a working phone number that the Hearing Officer can use to contact you for a hearing.

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.

If your request to vacate this dismissal is granted and your phone still is not working by the time of the rescheduled hearing, no further hearings will be scheduled with regard to this appeal.

### **Appeal Identification Number**

When communicating with NYSOH about this appeal, please refer to both the Appeal Identification Number and the NY State of Health 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

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- 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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