



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

## NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: October 20, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008569

[REDACTED]

Dear [REDACTED]

On March 23, 2016, New York State of Health (NYSOH) issued an eligibility determination notice, in relevant part, that you and your family did not qualify to select a health plan outside of the enrollment period for 2016. You requested an appeal insofar as your family's eligibility to select a health plan outside of the open enrollment period.

On September 21, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for October 17, 2016 at 11:00 am.

On October 17, 2016, a Hearing Officer from the NYSOH Appeals Unit attempted to contact you three times using the telephone number that you provided to NYSOH between 11:00 am and 11:30 am. On the third attempt an individual answered, stated that you were unavailable and not able to participate in the hearing at the scheduled time. The Hearing Officer asked for an alternative telephone number to speak with you, and a substitute number was not provided.

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 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).

## **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, 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 the Appeal Identification Number at the top of this notice.

## **How to Contact NYSOH**

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.

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



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