



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

NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: November 09, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000009146

[REDACTED]

Dear [REDACTED]

On April 26, 2016, New York State of Health (NYSOH) issued an enrollment notice confirming that as of April 25, 2016, your children were enrolled in a Child Health Plus plan with a plan enrollment start date of June 1, 2016. You requested an appeal insofar as the plan enrollment start date of that plan.

On October 19, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for November 3, 2016 at 11:00 am.

On November 3, 2016, a Hearing Officer from NYSOH Appeals Unit contacted you to conduct your scheduled hearing. You requested that your hearing be rescheduled for November 4, 2016 at 1:00 pm, and waived formal notice of the hearing.

On November 4, 2016, a Hearing Officer from the NYSOH Appeals Unit attempted to contact you using the telephone number that you provided to NYSOH between 1:00 pm and 1:30 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?

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).

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, 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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