



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

NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: November 07, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000009206

[REDACTED]

Dear [REDACTED]

On April 19, 2016, NY State of Health (NYSOH) issued a disenrollment notice, stating that your coverage had been terminated, effective February 29, 2016. You appealed this notification insofar as you were seeking to qualify for a special enrollment period to reenroll in a health plan for the remainder of the 2016 plan year.

On October 18, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for November 3, 2016, at 11:00 a.m.

On November 3, 2016, a Hearing Officer placed three calls to the telephone number that you provided to NYSOH, at 11:01 a.m., 11:11 a.m., and 11:31 a.m. On the third call attempt, a person identifying themselves as you answered but refused to provide either their date of birth or the last four digits of their Social Security number to confirm their identity. Accordingly, since we were unable to confirm this individual's identity, we could not proceed with the appeal.

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 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, 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.

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:



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).