



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

## NOTICE OF DISMISSAL – UNTIMELY APPEAL REQUEST

Notice Date: March 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000010450

[REDACTED]

Dear [REDACTED]

On August 8, 2015 NY State of Health (NYSOH) issued an eligibility determination notice stating your child was conditionally eligible for Medicaid Fee-for-Service coverage, effective August 1, 2015.

Also, on August 8, 2015 NYSOH issued an enrollment confirmation notice stating that your child was enrolled in a Medicaid Managed Care plan, effective September 1, 2015.

On November 25, 2015, NYSOH issued a disenrollment notice stating that your child's coverage in a Medicaid Managed Care plan would end, effective November 30, 2015. The notice stated that your child was no longer eligible to remain in his current health insurance.

Also, on November 25, 2015, NYSOH issued an eligibility determination notice stating that your child was eligible for Medicaid Fee-for-Service coverage, effective November 1, 2015.

On February 20, 2016, NYSOH issued an eligibility determination notice stating that your child was eligible for Medicaid Fee-for-Service coverage. The notice stated that the type of Medicaid coverage your child was eligible for did not require/allow you to enroll in a health plan.

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: 1-877-662-4886).

On June 22, 2016 you spoke to NYSOH's Account Review Unit and appealed your child's eligibility determination insofar as he was unable to enroll in a Medicaid Managed Care plan, effective December 1, 2015.

On January 27, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing, [REDACTED] acted as your Authorized Representative and assisted you with your testimony. The record was developed during the hearing and closed at the end of the hearing.

The record indicates that you are appealing the November 25, 2015 eligibility determination notice, and that your appeal was filed on June 22, 2016 regarding your child's Medicaid Fee-For-Service eligibility, effective December 1, 2015.

### **Why Your Appeal Request Is Not Valid**

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

For an appeal to have been valid on the issue of your child's eligibility for Medicaid Fee-for-Service coverage, as addressed in the November 25, 2015 notice, an appeal should have been filed by January 24, 2016. According to the credible evidence in the record, a formal appeal was not filed until June 22, 2016. This date is well beyond 60 days from the November 25, 2015 eligibility determination notice.

Therefore, there has been no valid timely appeal of the November 25, 2015 eligibility determination notice and your appeal on the issue of your child's eligibility for Medicaid Fee-for-Service coverage, as stated in that notice is DISMISSED.

### **How does this Dismissal Affect Your Eligibility?**

This decision does not change your child's current eligibility for or enrollment in a qualified health plan, or the monthly premium amount that you pay for your health plan.

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## **If You Think Your Appeal Should Not Be Dismissed**

If you think your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. In that writing, you must explain why you think this dismissal should be vacated.

If you ask us in writing to vacate this dismissal, NYSOH's Appeals Unit will review your request and send you a decision on that request.

If we deny your request to vacate this dismissal, we will tell you that in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed. No further action will be taken on it by NYSOH.

## **Appeal Identification Number**

When communicating with NYSOH about this appeal, please reference 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 45 CFR § 155.530.

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



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