



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

NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: February 3, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000011568

[REDACTED]

Dear [REDACTED]

On August 19, 2016, NY State of Health (NYSOH) issued a notice of enrollment determination, stating that you were enrolled in a Medicaid Managed Care plan, effective October 1, 2016. You appealed this determination.

On December 21, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for January 11, 2017, at 10:00 a.m.

On January 11, 2017, a Hearing Officer reached you and you requested an adjournment. The Hearing Officer granted the request and adjourned the matter to January 19, 2017 at 10:00 a.m. You were advised that if you did not answer the phone on that day, your appeal would be dismissed. Further, you agreed to waive your right to receive 15 days' written notice of the hearing.

On January 19, 2017, a Hearing Officer reached you and you agreed to waive the right to 15 days' written notice of the hearing. You again requested an adjournment and the Hearing Officer granted the request and adjourned the matter to January 31, 2017 at 10:00 a.m. You were advised that if you did not answer the phone on that day, your appeal would be dismissed. Further, you again agreed to waive your right to receive 15 days' written notice of the hearing.

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).

On January 31, 2017, a Hearing Officer placed three calls to the telephone number that you provided to NYSOH, at 10:02 a.m., 10:06 a.m., and 10:21 a.m., but was 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?

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 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.

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



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