



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

## NOTICE OF DISMISSAL – UNTIMELY APPEAL REQUEST

Notice Date: March 30, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014448

[REDACTED]

Dear [REDACTED]

On January 23, 2015, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2015.

Also on January 23, 2015, NYSOH issued an enrollment confirmation notice stating that your enrollment in a Medicaid Managed Care plan would begin March 1, 2015.

On December 18, 2015, NYSOH issued a notice of renewal stating that NYSOH did not have enough information from state and federal data sources to determine whether you could get help paying for your insurance. The notice directed you to update your account by January 15, 2016. The notice stated that if you miss the deadline, the financial assistance that you are receiving may end.

No updates were made to your NYSOH account by January 15, 2016.

On January 17, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost through NY State of Health. The notice stated that you no longer qualified for financial assistance, effective January 31, 2016, because you did not respond to the renewal notice.

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).

Also, on January 17, 2016, NYSOH issued a notice of disenrollment stating that your Medicaid Managed Care plan coverage would end effective January 31, 2016.

On January 26, 2016, you updated your NYSOH application.

On January 27, 2016, NYSOH issued a notice stating that the income information you provided does not match what NYSOH obtained from state and federal data sources. You were directed to provide income documentation by February 11, 2016 or NYSOH would not be able to make an eligibility determination.

No updates were made to your NYSOH account by February 11, 2016.

On March 16, 2016, NYSOH issued a notice redetermining your eligibility which stated that you were eligible to purchase a qualified health plan at full cost, effective April 1, 2016.

On October 8, 2016, you updated your NYSOH account.

On October 9, 2016, NYSOH issued a notice of enrollment confirmation stating that your enrollment in your Medicaid Managed Care plan would start November 1, 2016.

On October 11, 2016, NYSOH issued an eligibility redetermination stating that you were eligible for Medicaid, effective October 1, 2016.

On December 30, 2016, you spoke to NYSOH's Account Review Unit and appealed your eligibility determination insofar as you were no longer eligible for coverage in your Medicaid Managed Care plan, effective January 31, 2016.

On March 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

The record indicates the following: (1) you are appealing your loss of coverage from your Medicaid Managed Care plan, effective January 31, 2016, (2) on December 28, 2016 you filed a complaint about your loss of Medicaid coverage effective February 1, 2016, and (3) on December 30, 2016 a formal appeal was filed regarding your loss of Medicaid coverage beginning on February 1, 2016.

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## **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 eligibility for enrollment in your Medicaid Managed Care plan ending on January 31, 2016, as addressed in the January 17, 2016 notice, an appeal should have been filed by March 17, 2017. According to credible evidence in the record, you did not contact NYSOH until December 28, 2016 to file a formal complaint and a formal appeal was not filed until December 30, 2016. Both these dates are well beyond 60 days from the January 17, 2016 eligibility determination notice.

Therefore, there has been no valid timely appeal of the January 17, 2016 eligibility determination notice, and your appeal on the issue of eligibility for enrollment in your Medicaid Managed Care plan ending effective January 31, 2016 is DISMISSED.

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

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

## **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.

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).

## **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.

**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: 1-877-662-4886).

## **Getting Help in a Language Other than English**

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

### **Español (Spanish)**

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

### **中文 (Traditional Chinese)**

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

### **Kreyòl Ayisyen (Haitian Creole)**

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

### **中文 (Simplified Chinese)**

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您提供相应语种的口译服务。

### **Italiano (Italian)**

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

### **한국어 (Korean)**

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

### **Русский (Russian)**

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

### **العربية (Arabic)**

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

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).

### বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

### Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

### हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

### 日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

### नेपाली (Nepali)

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

### Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

### Twi (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bεtumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

### (Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

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**Tiếng Việt (Vietnamese)**

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

**אידיש (Yiddish)**

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.