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

NOTICE OF DISMISSAL – UNTIMELY APPEAL REQUEST

Notice Date: October 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020104

[redacted]

Dear [redacted]

On February 24, 2016, NYSOH issued an eligibility determination stating that your daughter [redacted] remained conditionally eligible for Medicaid, effective April 1, 2015. The notice directed you to provide proof of your daughter's citizenship status and Social Security number by May 23, 2016. The notice stated that if you did not provide the requested documentation by the due date that your daughter might be found ineligible for health insurance or receive less help with health insurance.

Also, on February 24, 2016, NYSOH issued an enrollment confirmation notice stating that your daughter [redacted] remained enrolled in a Medicaid Managed Care plan, since April 1, 2015.

Documentation was not received by May 23, 2016.

On June 3, 2016, NYSOH redetermined your family's eligibility.

On June 4, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that your daughter [redacted] was not eligible for Medicaid, Child Health Plus, an advance premium tax credit, the Essential Plan or to purchase a qualified health plan with NYSOH because you did not provide proof of her citizenship status or Social Security number. The eligibility was effective June 30, 2016.

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 June 4, 2016, NYSOH issued an eligibility determination notice stating that your spouse remained conditionally eligible for Medicaid, effective June 1, 2016. The notice directed her to provide proof of her immigration status by May 23, 2016.

Also on June 4, 2016, NYSOH issued an enrollment confirmation notice stating that your spouse remained enrolled in a Medicaid Managed Care plan, since November 1, 2014.

Also on June 4, 2016, NYSOH issued a disenrollment notice stating that your daughter [redacted] coverage in her Medicaid Managed Care plan was ending effective, June 30, 2016.

On April 13, 2017, NYSOH issued a notice of eligibility determination stating that your spouse was eligible for the Essential Plan, effective April 1, 2017 and your other children remained eligible for Medicaid, effective April 1, 2017.

Also on April 13, 2017, NYSOH issued a notice of enrollment confirmation stating that your spouse was enrolled in an Essential Plan, effective May 1, 2017 and your children were enrolled in a Medicaid Managed Care plan, effective April 1, 2017.

On June 28, 2017, you spoke to NYSOH's Account Review Unit and filed an appeal to obtain Retroactive Medicaid benefits for your daughters ([redacted]) for the months of January 2017, February 2017, and March 2017 and Essential Plan coverage for your spouse effective January 1, 2017.

On July 21, 2017, NYSOH records reflect that [redacted] Medicaid coverage was backdated for the months of January 2017, February 2017, and March 2017.

On July 24, 2017, NYSOH records reflect that your spouse's Essential Plan coverage was backdated to January 1, 2017.

On July 25, 2017, NYSOH issued an enrollment confirmation notice stating that your daughter, [redacted] remained enrolled in a Medicaid Managed Care plan effective October 1, 2016. The notice also stated that your spouse remained enrolled in an Essential Plan, effective January 1, 2017.

You had a telephone hearing on September 20, 2017. At the hearing, you testified that your two daughters had been granted Retroactive Medicaid benefits for the months of January 2017, February 2017, and March 2017. You also testified that your spouse had been granted Essential Plan coverage, effective January 1, 2017. At that time, you withdrew your previous appeal with respect to

your spouse and children. Also during the hearing, you testified that you wanted to appeal the June 4, 2016 determination which found that your daughter [redacted] Medicaid Managed Care plan coverage ended effective June 30, 2016, and that you were seeking Retroactive Medicaid benefits for your daughter [redacted] for the months of July 2016 through December 2016.

The record indicates the following (1) you are appealing the determination that stated that your daughter [redacted] Medicaid Managed Care plan ended, effective June 30, 2016, (2) on June 28, 2017, a formal appeal was filed regarding your daughter [redacted] Medicaid Managed Care plan ending effective June 30, 2016.

Why Your Appeal Request Is Not Valid

Individual applicants and enrollees must request a hearing within sixty (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 daughter [redacted] Medicaid Managed Care plan ending effective June 30, 2016, as addressed in the June 4, 2016 notice, an appeal should have been filed by August 30, 2016. According to the credible evidence in the record, you did not contact NYSOH until June 28, 2017 to file a formal appeal. This date is well beyond 60 days from the June 30, 2016 eligibility determination notice.

Therefore, there has been no valid timely appeal of the June 4, 2016 eligibility determination notice and your appeal on the issue of your daughter [redacted] Medicaid Managed Care plan ending effective, June 30, 2016 as stated in that notice is DISMISSED.

How does this Dismissal Affect Your Eligibility?

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

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

[redacted]

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。我们可以为您免费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)

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).

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.

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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 yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

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.

(Yiddish) אידיש

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.

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