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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: January 03, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000023530

On March 8, 2017, NY State of Health (NYSOH) received your updated application for financial assistance and you uploaded one document to your NYSOH account.

On March 9, 2017, NYSOH issued a notice stating that the income information that you entered into your application on March 8, 2017 did not match what NYSOH received from state and federal data sources. This notice further stated that more information was needed to confirm your eligibility and you needed to submit proof of income by March 23, 2017.

On March 17, 2017, NYSOH invalidated the income documentation you uploaded on March 8, 2017.

On March 18, 2017, NYSOH issued a notice stating that that the documentation NYSOH received did not confirm the information in your application. This notice directed you to submit additional income documentation by April 7, 2017.

On March 29, 2017, you faxed a six-page document to NYSOH; which was uploaded to your NYSOH account on April 3, 2017.

On April 10, 2017, NYSOH validated the faxed income documentation and an updated application was submitted on your behalf.

On April 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective March 1, 2017.

Also on April 11, 2017, NYSOH issued a notice regarding retroactive Medicaid stating that you were eligible for Medicaid from February 1, 2017 through February 29, 2017, because your monthly household income was at or below the monthly income limit for Medicaid eligibility.

On October 19, 2017, you filed an appeal. The appeal notes, dated October 19, 2017, stated that the reason for your appeal was the denial of Medicaid Premium Assistance payments (*see* Incident ██████).

However, you testified at the hearing on December 27, 2017, that you were not seeking Medicaid Premium Assistance payments. You further testified that you have third-party health insurance and Medicaid coverage. You testified that your medical bills are first being billed through your third-party health insurance and you are attempted to process the remainder of the bills through Medicaid. However, you testified, that Medicaid is denying payment for the remainder of the medical bills due to fact that the providers that rendered the medical services are out of network.

You testified that you filed the appeal because you would like Medicaid to pay for the remainder of the medical bills because you are unable to afford the remaining amount owed on the medical bills after the bills are processed by your third-party health insurance. You further testified that, while the doctors are out of network, they are the only doctors that are able to provide the medical care you need. You testified that, at the time of the hearing, you were not interested in Medicaid Premium Assistance payments.

Why Your Appeal Request Is Not Valid

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

After hearing your testimony, it was determined that you requested an appeal to dispute the fact that Medicaid is not approving payment for the remainder of your

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medical bills from out of network providers. You testified that you are seeking to have Medicaid cover the remaining amount owed on medical bills after claims were processed by your third-party health insurance. This issue relates to Medicaid coverage and what types of medical services Medicaid will pay for, which is not an issue that the Appeals Unit of NYSOH is authorized to address. Therefore, the NYSOH's Appeals Unit must dismiss your appeal.

You may have additional appeal rights outside of the Appeals Unit of New York State of Health, such as through NYS Office of Temporary and Disability Assistance.

How does this Dismissal Affect Your Eligibility?

This Decision does not affect your current eligibility.

You may have additional appeal rights outside of the Appeals Unit of New York State of Health, such as through NYS Office of Temporary and Disability Assistance.

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 and if your issue differs from the one discussed above.

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 and the Account ID 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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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)

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.

(Bengali)

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1-855-355-5777

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 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 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 کرم1-855-355-5777 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.