

**NEW YORK CITY-NOTICE OF DECISION ON PAID AND UNPAID MEDICAL BILLS:
ALIESSA/ADAMOLEKUN V. NOVELLO**

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE			
CASE NUMBER	CIN/RID NUMBER				
CASE NAME AND ADDRESS					
<div style="border: 1px solid black; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> [</div>				GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____	
				OR Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____	
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.	

We have already told you that you are a class member in the Aliessa/Adamolekun v. Novello case. The purpose of this notice is to tell you whether the Medicaid program can pay your medical bills for care you received from September 12, 1997, until August 5, 2004.

DECISION ON BILLS THAT YOU PAID

Approved paid bills: A check for \$_____ is being mailed to you. This pays you back for medical bills that you paid or that another person paid for you. Please see the enclosed form called "Reimbursement Detail Form/ Paid Bills" for a list of these approved paid bills and the amount of money you will be paid for each bill.

Denied paid bills: We are denying your request for payment of one or more of the bills you sent us that you paid or that someone else paid for you. Please see the enclosed "Reimbursement Detail Form/Paid Bills" for a list of these denied paid bills and the reason we are denying you payment.

DECISION ON BILLS THAT YOU DID NOT PAY

Approved unpaid bills: One or more of the bills you sent us were not paid. Please see the enclosed form called "Reimbursement Detail Form/ Unpaid Bills" for a list of these approved unpaid bills. Please tell your doctor or other provider to submit these approved unpaid bills to:

**The Medical Assistance Program
Aliessa/Adamolekun Eligibility Review Unit
GPO Box 2625
New York, NY 10116.**

Denied unpaid bills: The Medicaid program cannot pay your doctor or other provider for one or more of the unpaid bills you sent us. Please see the enclosed "Reimbursement Detail Form/Unpaid Bills" for a list of these denied unpaid bills and the reason that Medicaid cannot pay your provider.

THE LAW, REGULATION OR COURT DECISION THAT ALLOWS US TO DO THIS IS 18 NYCRR SECTION 360-7.5 AND COURT ORDER IN ALIESSA/ADAMOLEKUN V. NOVELLO.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

CONFERENCE AND FAIR HEARING INFORMATION

CONFERENCE: (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us at 212-630-0996, or write to us at Medical Assistance Programs, Conference Unit, 330 W. 34th Street, Third Floor, New York, NY 10001, to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. This is not the way to request a fair hearing. If you ask for a conference, you are still entitled to a fair hearing.

STATE FAIR HEARING - Deadline for Request: If you want the State to review our decision about your Medical Assistance you must ask for a fair hearing within 60 days from the date of this notice.

How to Request a Fair Hearing: You can ask for a fair hearing in writing or by telephone, in person or over the Internet.

Write: Send a copy of this notice completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

Telephone: 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

Fax: Send a copy of this notice to fax number (518) 473-6735.

Walk-In: Bring a copy of this notice to the New York State Office of Temporary and Disability Assistance at:
- 14 Boerum Place, 1st Floor, Brooklyn, or
- 330 West 34th Street, 3rd Floor, Manhattan

On-Line: Complete and send the online request form at: http://www.otda.state.ny.us/oah/forms.asp

If you cannot reach the State by phone, please write to request a fair hearing before the deadline for requesting a fair hearing.

REQUEST FOR A FAIR HEARING

I want a fair hearing. This agency's action was wrong because: _____

Print Name: _____ Case Number _____

Address: _____ Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case. If you need an interpreter, please advise the State when you request the hearing.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society, other legal advocate group, or by checking your Yellow Pages under "Lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front page of this notice or write us at the address printed at the top of the front page of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. Usually they will be sent to you within three working days of when you asked for them. If your hearing is within five working days of when you ask for them, your documents may be given to you within three working days of the request or at the hearing.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at 212-630-0996.

IF YOU WOULD LIKE MORE INFORMATION WITH RESPECT TO THIS NOTICE, PLEASE CALL:
LEGAL AID SOCIETY at 212-577-3575 or toll free at 1-888-500-2455;
NEW YORK LEGAL ASSISTANCE GROUP at 212 -613-5001; or
GREATER UPSTATE LAW PROJECT toll free at 1-800-724-0490

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.