

<Date>

<Barcode> <Letter Code>
<Name>
<Address>
<City>, <State>, <Zip>

We cannot disenroll you at this time.

Dear <Member Name>:

<CIN>

You've asked to be disenrolled from (leave) <Plan>, a FIDA (Fully Integrated Duals Advantage) plan. We cannot process your request to disenroll from <Plan> because:

Your written request is incomplete in that it is not signed by you or we need additional information to process your request.

Please call us so that we can process your request to leave <Plan Name>.

This action has been taken in accordance with Public Health Law 4403-f.

You have the right to ask us to review our decision. If you still disagree, you have the right to appeal our decision.

You may ask New York Medicaid Choice and/or the State of New York to review this decision.

- If you disagree and would like to talk to someone about this decision, you may ask for a "conference." A conference is an informal meeting in person or on the phone. At the conference, you may ask why New York Medicaid Choice made the decision. You may also provide more information and ask New York Medicaid Choice to look again at the decision.
- If you still disagree, you may "appeal," or formally ask the state of New York to review the decision. To do that, you can ask for a State fair hearing.

Please read “How to Ask New York Medicaid Choice and/or the State of New York to Review This Decision” included in the envelope. It has more information on how to ask for a conference and/or a State fair hearing.

If you decide to ask for a State fair hearing, please read, for more information, “You May Ask for a Fair Hearing within 60 Days from the Date of This Notice”, also included in the envelope.

If you need help understanding this letter or if you have questions about your rights, please call the ombudsman office through the Independent Consumer Advocacy Network (ICAN) at the phone number on the last page of this letter.

Thank you,
New York Medicaid Choice

DRAFT

Questions?

New York Medicaid Choice

For questions about FIDA program and Medicaid benefits

Call: 1-855-600-3432
TTY users: 1-888-329-1541
A free interpreter: 1-855-600-3432

Monday-Friday, 8:30 am – 8:00 pm
Saturday, 10:00 am – 6:00 pm

The call and the help are free.

Online: www.nymedicaidchoice.com

Medicare

For questions about your Medicare benefits

Call: 1-800-MEDICARE (1-800-633-4227)
TTY users: 1-877-486-2048

24 hours a day, 7 days a week

Online: www.medicare.gov

Independent Consumer Advocacy Network (ICAN)

For questions about your rights

Call: 1-844-614-8800
TTY users: 711
A free interpreter: 1-844-614-8800

Monday-Friday, 8:00 am – 8:00 pm

The call and the help are free.

Online: www.icannys.org

How to Ask New York Medicaid Choice and/or the State of New York to Review This Decision

Your right to a conference:

You may have a phone or in-person conference with New York Medicaid Choice (NYMC) to review a decision regarding your eligibility. If you want a conference, you should ask for one as soon as possible. At the conference, if an NYMC representative finds that the decision is wrong, or if, because of information you provide, he or she changes the decision, NYMC will send you a new notice. Please see NYMC contact information below.

To ask for a fair hearing:

If you still disagree with NYMC, you may ask for a State fair hearing. To ask for a fair hearing, please see below the contact information of the New York State Office of Temporary Disability and Assistance.

I want a fair hearing. The Agency's decision is wrong because:

Your name: _____

Name of your plan: _____

Your address: _____

Your phone #: _____

Case #: _____ CIN #: _____

Your signature: _____ Date: _____

To ask New York Medicaid Choice for a conference:

Call: 1-855-600-3432

TTY users: 1-888-329-1541

A free interpreter: 1-855-600-3432

Fax: 1-917-228-8899

Monday-Friday, 8:30 am – 8:00 pm

Saturday, 10:00 am – 6:00 pm

Mail: Conference Unit
New York Medicaid Choice
P.O. Box 5016
New York, NY 10274

To ask Office of Temporary Disability and Assistance for a fair hearing:

Call: 1-800-342-3334

Fax: 1-518-473-6735.

Walk-In:

Office of Administrative Hearings
14 Boerum Place, 1st floor
Brooklyn, New York

Mail: Fair Hearing Section, OTDA
P.O. Box 22023,
Albany, NY, 12201-2023

Online:

www.otda.ny.gov/hearings/

You May Ask for a Fair Hearing within 60 Days from the Date of This Notice

If you ask for a fair hearing:

The New York State Office of Temporary Disability and Assistance will send you a notice informing you of the time and place of the hearing. You have the right to be represented by a legal counsel, a relative, a friend or other person, or represent yourself. At the hearing, you, your attorney or other representative will have an opportunity to present written or oral evidence to show why the decision is wrong, as well as an opportunity to question any persons who appear at the hearing. Also, you have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents that may be helpful in presenting your case.

If you need legal help:

If you need free legal help, you may be able to obtain such assistance by contacting the Independent Consumer Advocacy Network (ICAN), your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

If you need to get a copy of your case file:

To help you get ready for the hearing, you have the right to look at your case file. Call or write New York Medicaid Choice at the phone number below to get free copies of your case file. We will also give the same copies to the hearing officer at the fair hearing. You can also get free copies of other documents from your file that you may need to prepare for your fair hearing.

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 ask for them. If your hearing is within three working days of when you ask for them, your case file documents may be given to you at the fair hearing.

New York Medicaid Choice

Call: 1-855-600-3432
TTY users: 1-888-329-1541
A free interpreter: 1-855-600-3432
Fax: 1-917-228-8899

Mail: Record Access Unit
New York Medicaid Choice
P.O. Box 5016
New York, NY 10274

Monday-Friday, 8:30 am – 8:00 pm
Saturday, 10:00 am – 6:00 pm

English

This is an important document. If you need help to understand it, please call 1-855-600-3432. We can give you an interpreter for free.

Español

Spanish

Éste es un documento importante. Si necesita ayuda para entenderlo, por favor llame al 1-855-600-3432. Le proporcionaremos un intérprete gratuito.

繁體字

Traditional Chinese

這是一份重要文件, 如果您需要翻譯服務閱讀此文件, 請撥打電話至 1-855-600-3432. 該項服務免費。

Kreyòl Ayisyen

Haitian Creole

Sa a se yon dokiman enpòtan. Si ou bezwen èd pou konprann li, tanpri rele: 1-855-600-3432. Y ap ba ou yon entèprèt gratis.

Italiano

Italian

Il presente documento è importante. Per qualsiasi chiarimento può chiamare il numero 1-855-600-3432. Un interprete sarà disponibile gratuitamente.

한국어

Korean

이것은 중요한 문서입니다. 문서를 이해하는 데 있어 도움이 필요하시면, 연락해 주십시오: 1-855-600-3432. 무료통역이 제공됩니다.

Русский

Russian

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-600-3432. Переводчик предоставляется бесплатно.