Important: This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

[PLAN NAME/LOGO]	**Appeal Level: 1**

APPEAL DISMISSAL NOTICE

Name: **Date of Notice:**

Enrollee Number:
[*Insert if available:* **Appeal Number:**]

[*Insert other identifying information, as necessary (e.g., provider name, enrollee's Medicaid number, service subject to notice, date of service)*]

Dear <Enrollee name>,

<Plan name> received your appeal on <date appeal received, orally or in writing> about the following action: [*Insert a detailed description of the Plan action (e.g. denial, reduction, etc.) being appealed and the benefits involved. Also, include the original rationale for the Plan action that is the basis of the enrollee's appeal and date of that action.*]

We can't process your appeal because: *(explain the specific reason for dismissal and what is missing from the request -- e.g., person making the request is not a proper party and there isn't an appointment of representation (AOR) form; lack of waiver of liability (WOL) for a request filed by a non-contract provider; untimely filing of appeal and there isn't good cause for the late filing; a party submits a timely request for withdrawal of the reconsideration request.)*

If you have questions about this notice, you may contact us at: [insert plan contact info]

If you disagree with our decision to dismiss your appeal request, you have two options:

1. **You have the right to ask us to vacate (set aside) the dismissal action.** If we determine there is good cause to vacate the dismissal because <*insert reason for finding good cause--e.g., a finding that the person who made the request is a proper party*>, we will vacate the dismissal and review your appeal request. Your request to vacate this dismissal

must be received by our office at <*insert address/fax/phone*> within **6 months** of the date of this notice. Include a copy of this *Notice of Dismissal of Appeal Request* along with any supporting information with your request.

2. If you think we should have accepted your appeal because there was a good reason that it was late, you can ask the **Office of Administrative Hearings (OAH)** to review our decision to dismiss your case. OAH is an independent organization that is not connected to <plan name>. If you ask OAH to review your case, someone from OAH will contact you to schedule a hearing.

Please send a copy of this notice, as well as any information about why your appeal should be reviewed even though it was late to OAH at the following address:

Office of Administrative Hearings
Mailing Address: Integrated Appeals/OAH, PO Box 1930, Albany, NY 12201

Phone: 1-844-523-8777
TTY Phone: Call 711, then follow the prompts to dial 844-523-8777
Fax: 518-473-8783

Email: otda.sm.MAP.Integrated.Appeals.Office@otda.ny.gov

We have included a form that you can use to send your appeal to OAH below. We recommend keeping a copy of everything for your records.

Getting your case file and submitting evidence

If you decide to make an appeal to OAH, you can ask us to send you, for free, a copy of the evidence packet (the information we will use to support our decision) that will help you, at your fair hearing, show why our decision was wrong. We recommend keeping a copy of everything for your records.

If you want someone to represent you

You can have someone else represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, or attorney.

If you already named someone to represent you when you asked for this appeal, or if you have someone who is otherwise able to act for you because he or she is a legal guardian, power of attorney, or otherwise authorized to make health care decisions on your behalf, you do not have to do anything else.

If you have not already named someone to represent you and want to choose someone now, before the person can act for you, both you and the person you want to act for you must sign and date a statement confirming this is what you want. You can write a letter or use the Appointment of Representative form available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. Send your letter or form to OAH by fax or mail. Keep a copy for your records. If you have any questions about naming your representative, such as what to say in your

letter, contact OAH using the information above or call us at: <phone number>. TTY users call <TTY number>.

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the Medicaid Advantage Plus (MAP) program. ICAN is independent, and the services are available to you for free. They can help answer your questions about the appeals process, give you advice. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

[*Plans must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:*
A copy of this notice has been sent to: <name>
<address>
<phone number>]

Get help & more information

(TTY users call 711, then use the phone numbers below)

- <Plan name>
  Website: <plan website>
  Toll Free Phone: <phone number>
  TTY users call: <TTY number>
  <days and hours of operation>

Independent Consumer Advocacy Network (ICAN)
633 Third Ave, 10th Floor
New York, NY 10017
Website: http://icannys.org
Email: ICAN@cssny.org
Toll Free Phone: 1-844-614-8800
8:00am – 6:00pm, Monday – Sunday

- 1-800-MEDICARE (1-800-633-4227)
  TTY users call: 1-877-486-2048
  24 hours a day, 7 days a week
- NYS Department of Health
  Bureau of Managed Long Term Care
  Toll Free Phone: 1-866-712-7197
- Medicare Rights Center
  Toll Free Phone: 1-888-HMO-9050

[*Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidance and any state-specific guidance provided by the New York State Department of Health.*]

Medicaid Advantage Plus Program (MAP)

DISMISSAL APPEAL FORM

Mail this form to: Integrated Appeals/OAH, PO Box 1930, Albany, NY 12201
Fax to: 518-473-8783
Email to: otda.sm.MAP.Integrated.Appeals.Office@otda.ny.gov

Enrollee Information [*the plan should auto-populate the enrollees Information*]

Name: <First Name> <MI> <Last Name>
Enrollee ID: <Enrollee ID>
Address: <Address> <City, State Zip>
Home Phone: <Home Phone> Cell Phone: <Cell Phone>
Date of Birth: <DOB>
[*Insert if available:* Appeal Number:]

Requester (if different from above)

Name: ____________________ E- mail: ____________________

Address: ____________________ Fax #: (______) __________

City: ______________ State: ______ Zip Code: __________ Phone #: (______) __________

Does the Requester intend to represent the Enrollee? ☐ YES ☐ NO

Appeal Information

Today's date: ____________________ Service or item you requested: ____________________

____

Date on the Coverage Determination Notice (if you have it): ____________________

Reason that you made the request late: ____________________

____

____

☐ Is an Interpreter needed? ☐ YES ☐ NO Language: ____________________

☐ I need an accommodation for my disability for this appeal. The accommodation(s) I need are:

____

☐ I enclosed additional documents for consideration for the appeal.