UPSTATE-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		
		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 follow the Department’s existing procedures for submitting a Medicaid claim for this service.

☐ **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

Upstate

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number 1-800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735 **OR**

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

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is 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.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting 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 front of this notice.

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 of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

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 the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

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.