Attachment V
MA Only

**LDSS-3869** (9/10)

# NOTICE OF DECISION ON REIMBURSEMENT OF MEDICAL BILLS BY THE MEDICAL ASSISTANCE PROGRAM

| NOTICE DATE: | | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>**OR** Agency Conference _____<br>Fair Hearing Information and Assistance _____<br>Record Access _____<br>Legal Assistance Information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

This notice is to advise you of this Department's decision regarding reimbursement of medical bills.

☐ The provider(s) listed on the enclosed OHIP-0032 (Medical Assistance Reimbursement Detail form) is (are) to be paid for services to you or your dependents for the amount(s) shown. The form details the bill(s) you sent us.

☐ A check for $ _____ is being mailed to you. This represents a reimbursement (payment) to you for medical services which you paid. The enclosed form details these reimbursement amounts.

These payments are being made as a result of your fair hearing, agency (re)consideration, or as a result of a court case, pursuant to the notice(s) dated _____.

In computing the amount of these checks, the Department reviewed the bill(s) sent to us. These bills totaled $_____. Denied bills, if any, are listed along with the reason(s) for denial on the enclosed OHIP-0032 (Medical Assistance Reimbursement Detail form).

The remaining bills, if any, are to be paid at the Medical Assistance rate in effect at the time the services were rendered (less your excess income, if any).

☐ The bills submitted are not reimbursable by the Medical Assistance Program. The reason(s) for denial are listed on the enclosed OHIP-0032 (Medical Assistance Reimbursement Detail Form).

The law and/or regulation which allow us to do this is 18 NYCRR 360-7.5(a)(1).

*REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, 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**

**LDSS-3869** (9/10) Reverse

**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: 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: **https://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.

**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.