NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

NOTICE OF MEDICAID PAYMENT OF THE MEDICARE PART A AND/OR PART B PREMIUM

DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) 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.

This Department will:

☐ **CONTINUE** payment of Medicare ☐ Part A and/or ☐ Part B premium effective ______________________

for Name ____________________________________, Client ID # ______________________

☐ **DISCONTINUE** payment of Medicare ☐ Part A and/or ☐ Part B premium effective ____________________

for Name ____________________________________, Client ID # ______________________

Reason:

☐ Our records indicate that this person is deceased.

☐ Our records indicate that this person is no longer a resident of New York State.

☐ This is because it is not cost effective.

☐ Failure to recertify.

Our records indicate that we have previously closed your Medicaid case for failure to recertify. Payment of your Medicare premium should have ended at the same time your Medicaid case was closed. Due to an error on our part this did not occur. Therefore, we will now discontinue payment of your Medicare premium.

☐ Your Medicaid case is no longer active.

Our records indicate that we have previously closed your Medicaid case because your income or resources were too high. Payment of your Medicare premium should have ended at the same time. Due to an error on our part this did not occur. Therefore, we will now discontinue payment of your Medicare premium.

☐ Other ____

____

☐ **FURTHER INFORMATION IS NEEDED**
We do not have enough current information to determine if you are eligible for payment of your Medicare premium. If you return the enclosed “Medicare Savings Program Application” within 10 days, and we determine that you are eligible, we will continue payment of your Medicare premium.

The regulation that allows us to do this is Section 367-a(3)(d)(1) of the Social Services Law.

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

CONFERENCE: (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us at 718-637-2426, write to us at HRA Division of Fair Hearing, 250 Livingston Street, 6th Floor, Brooklyn, New York 11201, 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.

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. If you call or write to us, we will also make available to you without charge specific policy materials necessary for you to decide whether to request a fair hearing or to prepare for the hearing. Policy materials that may be available to you include documents such as: Administrative Directives, General Information System messages, Informational Letters, portions of the Medicaid Reference Guide, Department of Health Medicaid Update newsletters and Local Commissioner Memorandums. To ask for documents, you may call us at 718-637-2426, fax us at 917-639-9355 or write to us at: HRA Division of Fair Hearing, 250 Livingston Street, 6th Floor, Brooklyn, New York 11201. If you want free copies of specific policy materials or 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 718-637-2426.

STATE FAIR HEARING - Deadline for Request: If you want the State to review our decision about your Medicaid 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, 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: (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:

- 5 Beaver Street, New York, New York 10004

On-Line: Complete and send the online request form at: **https://www.otda.ny.gov/oah/forms.asp**

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

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medicaid benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medicaid benefits, as described in this notice, prior to the issuance of the fair hearing decision.

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."

ATTENTION: Children under 19 years of age who are not eligible for Medicaid or other health insurance may be eligible for Child Health Plus Insurance. The plan provides health care insurance for children. Call 1-800-698-4543 for information.