NOTICE OF ACTION ON THE MEDICARE PART B BUY-IN PROGRAM

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	New York State Department of Health Office of Health Insurance Programs Third Party Liability Unit One Commerce Plaza – Suite 816 Albany, New York 12210
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP 1-518-473-7687 OR Agency Conference 1-518-473-7687__ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT NAME Third Party Liability	TELEPHONE NO. 1-518-473-7687

This notice is to advise you that the Medicaid payment of your Medicare Part B premium will be discontinued effective

Payment of your Medicare premium is being discontinued because you are no longer receiving New York State Medicaid and we have received information from the Social Security Administration that you are now receiving your Social Security benefits outside of the United States. The Medicaid payment of the Medicare Part B premium by the State of New York can only be made on behalf of New York State residents.

If you want to cancel your Medicare Part B enrollment, contact the Social Security Administration:

By mail: Social Security Administration
Office of International Operations
PO Box 17769
Baltimore, Maryland 21235-7769

By phone: 1-800-772-1213 if calling within the United States

Or via the internet: www.socialsecurity.gov/foreign/index.html

If you do not to cancel your Medicare Part B enrollment, you will be responsible for payment of the Medicare Part B premiums.

The law(s) or regulation(s) which allows us to do this is NYCRR 360-3.5.

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.