# Appeal Request – Instructions

## INSTRUCTIONS TO HELP YOU COMPLETE A NY STATE OF HEALTH APPEAL REQUEST

### Timeframe to request an appeal

You must submit your appeal request **within 60 days** of the date on the NY State of Health notice you are appealing.

### How to submit this form

Complete and sign the form, and attach copies of any supporting documents. Also keep a copy for yourself.

You may submit this form in any of the following ways:

- Upload the form by logging into your account on our website (www.nystateofhealth.ny.gov);
- Fax the form to 1-855-900-5557;
- Mail the form to:
  NY State of Health Appeals Unit
  P.O. Box 11729
  Albany, NY 12211

**You can also make a request by calling us at 1-855-355-5777 (TTY: 1-800-662-1220).**
If you call us, you do not need to send us this form.

### Keeping your coverage during your appeal

If you would like to keep your eligibility and coverage while the Appeals Unit decides your appeal, ask for it by checking the box in **Section 4.** We will send you a notice telling you if we approved your request.

**IMPORTANT: If you lose your appeal you may be responsible for the cost of your coverage during this period.**

### Fast-tracking (Expediting) your appeal

In **Section 5**, you must say why you need to fast-track it. For example, if your health is likely to get much worse with the normal wait for a hearing, you should ask us to fast-track the process. You must send us a note from your doctor backing up your reason for needing to fast-track your appeal.

### How to get help with this form

Call NY State of Health at 1-855-355-5777 (TTY: 1-800-662-1220) to get help reading this form in English or other languages or to get this form in other formats like large print.

New York State Department of Health
NY State of Health

# Appeal Request

## SECTION 1 Tell us about the person who is requesting this appeal (also called the "appellant").

Name _____ Date of birth _____
FIRST NAME, MIDDLE NAME, LAST NAME — MM/DD/YYYY

Address _____ _____ Daytime phone number _____
STREET — APARTMENT OR SUITE NUMBER — AREA CODE

_____ _____ _____
CITY — STATE — ZIP CODE

If other members of your household are appealing, write their names and dates of birth below. Use extra paper, if necessary.

**Note:** The outcome of an appeal could change the eligibility of other members of your household, even if they do not appeal their own eligibility determinations.

Name _____ Date of birth _____
FIRST NAME, MIDDLE NAME, LAST NAME — MM/DD/YYYY

Name _____ Date of birth _____
FIRST NAME, MIDDLE NAME, LAST NAME — MM/DD/YYYY

Name _____ Date of birth _____
FIRST NAME, MIDDLE NAME, LAST NAME — MM/DD/YYYY

## SECTION 2 Tell us why you are appealing.

What is the notice date? (if applicable) _____

What is the NY State of Health Account ID # (printed on the first page of the notice)?
**AC** _____

**Generally, you may appeal the following NY State of Health determinations. Check all that apply.**

NY State of Health determined that I was not eligible for:
(Select statements that apply based on your NY State of Health eligibility notice.)

- ☐ Medicaid, Essential Plan, or Child Health Plus
- ☐ Financial Assistance (premium tax credits or cost sharing reductions)
- ☐ Enrolling in or changing health plans through NY State of Health outside a regular Open Enrollment Period
- ☐ Reimbursement of health insurance premiums

☐ I disagree with the amount of financial assistance (premium tax credits, cost sharing reductions, or Child Health Plus or Essential Plan premium amount).

☐ NY State of Health did not provide me a timely eligibility determination after I applied.
Enter the date of your application, if applicable. _____
MM/DD/YYYY

## SECTION 3 Tell us more about why you are requesting this appeal (optional). Use extra paper, if necessary.

## SECTION 4 Ask us to continue your eligibility or coverage during your appeal.

☐ Continue my eligibility or coverage until the Appeals Unit of NY State of Health makes a decision about my appeal.

Checking the above box means that your eligibility or coverage will stay the same until a decision is made about your appeal. If you are covered by Medicaid, you will continue to be covered by Medicaid. If you are enrolled in the Essential Plan or Child Health Plus, or receive tax credits to help pay for coverage, the level of help you receive will stay the same.

**IMPORTANT: If you lose your appeal you may be responsible for the cost of your coverage during this period.**

## SECTION 5 Ask to fast-track (expedite) your appeal.

**If you have an immediate need for health services and a delay would seriously jeopardize your life, health, or ability to gain, maintain, or get back maximum function, you can ask for an expedited (faster) appeal.**

☐ I need an expedited appeal.

Please explain the reason you need an expedited appeal. Use extra paper, if necessary. You must include medical documents like a doctor's note to support your request. Please send us copies. Keep all original documents.

## SECTION 6 Signature

Please sign this form to complete your appeal request. If someone other than the appellant is signing, please indicate your relationship to the appellant.

Signature _____

Print your name _____ Date _____
MM/DD/YYYY

Relationship to the Appellant _____