Commonwealth of Massachusetts
Executive Office of Health
and Human Services
Office of Medicaid
www.mass.gov/masshealth

EDMC
P.O. BOX 4405
TAUNTON MA 02780-0968

Tel: (800) 322-1448
TTY: (800) 497-4648
Fax: (857) 323-8300

Medicaid ID : [redacted]

550/T *001927*
[redacted]

Attn: [redacted] Re: Notice sent to [redacted]

Date: 09/29/2023 Notice: 65521230 SSN: XXX-XX-[redacted]

Dear [redacted]

Important! This health-care benefits notice tells you the decisions we have made about certain programs that you may be eligible for. Please read the whole notice to find out about your health-care benefits.

MassHealth

MassHealth is ending coverage for the following members who had been receiving MassHealth benefits. The coverage will end only for family members listed below.

Name	SSN/DOB	Coverage End Date	Medicaid ID
[redacted]	XXX-XX-[redacted]	10/13/2023	[redacted]

Reason and Manual Citation
You did not give MassHealth the information it needs to decide your eligibility within the required time frame. 130 CMR 515.008

Your current MassHealth coverage will stop on the effective date listed above.

continued...

If you are still interested in receiving MassHealth benefits, send the information we requested to us at the address listed above. When we receive this information, MassHealth will review your case to see if your family may be eligible to receive MassHealth. You should send your verifications to MassHealth as soon as possible because the date of your eligibility will depend on when we receive these verifications.

Call the phone number at the top of this notice if you have any questions.

Call the phone number at the top of this notice if you have any questions about this notice. If you don't have a copy of the Member Booklet, please call to request one. It has important information about MassHealth coverage and rules.

For information about appealing our decisions, see the Request for a Fair Hearing page of this notice.

Health Safety Net

The Health Safety Net will not pay for services given to the individual(s) listed below. You must pay for services you get at a hospital or community health center. Please call the number at the top of this notice if you have any questions about this decision.

Name	SSN	Medicaid ID
[redacted]	XXX-XX-[redacted]	[redacted]

Reason and Manual Citation
You did not give MassHealth the information it needs to decide your eligibility within the required time frame. 130 CMR 515.008

If you have questions about this Health Safety Net decision, please call the number at the top of this notice. If you do not agree with this Health Safety Net decision, you may contact the Health Safety Net, Attn: HSN Grievances, 100 Hancock Street, 6th Floor, Quincy, MA 02171, or you can call them at 1-877-910-2100.

What proof was not provided to MassHealth in the time allowed?

Verification of the following information from:

[redacted]

- Income from Private Pension [redacted]
  This income was on file. Please provide current statement showing showing gross monthly benefit amount
- [redacted]

HOW TO ASK FOR A FAIR HEARING

Your Right to Appeal: If you disagree with the action taken by MassHealth, you have the right to appeal and ask for a hearing before an impartial hearing officer. You can also request a hearing if MassHealth did not act on your request in a reasonable time.

How to Appeal: You can fill out this hearing request form and send it with a copy of the notice you are appealing to the **Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th floor, Quincy, MA 02171** or you can fax or efax these materials to **(617) 887-8797.** You can also call **(800) 841-2900** to fill out your request for a hearing form by telephone. If you have a question about your hearing, call **(617) 847-1200** or **(800) 655-0338.**

The Board of Hearings must receive your completed, signed request within 60 calendar days from the date you received the notice of our action. If you did not receive a written notice of the action to be taken, or MassHealth did not take an action on your application, you must file your request no later than 120 calendar days from the date the action took place or the date of the application.

If You Are Now Getting MassHealth Benefits: You may be eligible to keep your benefits between the time you appeal and the time that the Board of Hearings makes a decision to approve or deny your appeal. If you decide to keep your benefits between the time the appeal is pending, and then you lose your appeal, you may have to pay back the cost of the benefits you received. If you do not get benefits, and then you win your appeal, we will restore your benefits. You will keep your benefits if the hearing form is received either before the benefit stops or within 10 calendar days from the mailing date of the MassHealth notice, whichever is later. Please mark your choice in the **Other Information** section of the form.

Date of Fair Hearing: At least 10 days before the hearing, we will send you a notice telling you the date, time, and place of the hearing. Your hearing may be conducted by phone. You can ask us to reschedule a hearing, but you must have good cause. If you do not reschedule or appear on time to the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing: At the hearing, you may have a lawyer or other person represent you, or you may represent yourself. We will not pay for anyone to represent you. You may contact a local legal aid service or community agency to see if you can receive advice or representation at no cost. A hearing request can also be filed on your behalf by an individual authorized to act on your behalf. If someone other than a lawyer is acting on your behalf, please attach a copy of the document(s) authorizing that person to file a hearing request on your behalf (for example, Power of Attorney, current Guardian or Conservator, an invoked Health Care Proxy).

If You Need an Interpreter, Assistive Device, or Other Accommodation: If you do not understand English or if you are hearing or sight impaired, we will provide an interpreter or assistive device at the hearing at no cost to you. We will also make other reasonable accommodations a person with a disability may need to participate in the hearing. Please tell us what you need in the **Other Information** section of the form.

Your Right to Review Your Case File: You and/or your representative can review your case file before the hearing. If you wish to review your case file, call (800) 841-2900, TTY: (800) 497-4648 (for people who are deaf, hard of hearing, or speech disabled).

Your Right to Ask to Subpoena Witnesses and Your Right to Question: You or your representative may write to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and cross-examine witnesses at the hearing. This means you can ask questions of witnesses. The hearing officer will make a decision based on all evidence presented at the hearing.

Impact on Other Household Members: Note that an appeal decision for one household member may change eligibility for other household members. If that happens, affected household members will receive a new eligibility notice explaining the changes.

FAIR HEARING REQUEST FORM

Name: [redacted]
Notice: 65521230

Member ID: [redacted]
Date: 09/29/2023

First Name | Middle Initial | Last Name

Mailing address | City | State | Zip

Phone number | Member ID | Date of Birth

Reason For Your Appeal (Circle any reason(s) that may apply.)

Income | Citizenship/Immigration Status | Access to other insurance
Family Size | Residency | Incarceration status
Other: _____

Please explain why you are appealing. Attach any documents that support your reason.

_____

_____

Other Information (Check all that apply.)

__ I accept the proposed change in my coverage during the appeal process. If you check this line and you win your appeal, we will restore your original level of benefits.

__ I want to keep the benefits during the appeal process that I was receiving before. If you check this line and you lose your appeal, you may have to pay back the cost of the benefits you received during your appeal.

__ I need an interpreter. My language is _____ (We will provide the interpreter for the hearing.)

__ I need an assistive device to communicate at a hearing. (Describe what type of device you need, and we will provide an assistive device for the hearing.) _____

__ I need another accommodation for a disability. (Describe the accommodation needed.)

_____

__ I need an expedited hearing

__ I want a phone hearing. My number is _____

Appeal Representative, if you have one:

_____
Name | Phone number

Mailing address | City | State | Zip

Signature

The information on this form is true and accurate, to the best of my knowledge. I authorize MassHealth to provide me and my representative, if I have one, with my individual information, including federal and state tax information used in the determination of my eligibility, for purposes of this appeal process.

_____
Signature (Sign) | Date | First and Last Name (Print)

If this is signed by someone other than an appellant 18 years of age or older who has authority to file, please attach a copy of your authority to file the appeal on behalf of the appellant (for example, a copy of your power of attorney document; evidence of a current court appointment for a personal representative, guardian, or conservator; or a copy of both a health care proxy and a provider letter verifying that the proxy is in effect).