<Date>

<Name>  
<Address>  
<City>, <State> <ZIP>

<Name>:

<Plan name> asked Medicare and New York Medicaid for permission to remove you from <plan name>.

On <enter date of advance notice>, <plan name> sent you a letter saying that your behavior was disruptive. In the letter, we asked you to change your behavior to be able to stay in our plan.

Because you did not change your behavior by <insert date provided in advance notice>, we have asked Medicare and New York Medicaid for permission to remove you from <plan name>.

Why we found your behavior disruptive:

<Plan to insert brief description*,* in plain English*,* of the disruptive behavior including the date(s) of the behavior, how it is disruptive, and to whom it is disruptive.>

We asked you to change this behavior:

<Plan to insert brief description*,* in plain English*,* of the changes the plan wants to see made by the Participant and a date (if applicable) by when the changes need to be made.>

We have asked for permission to remove you from <plan name>.

You will get a separate letter when Medicare and New York Medicaid make their decision about whether you can stay in <plan name>. If you are removed from <plan name>, that means you will no longer be able to get your Medicare and Medicaid services through <plan name>. The notice will explain your appeal rights.

**If you need help understanding this letter or have questions about your rights,** please call the Independent Consumer Advocacy Network (ICAN) at the phone number in the enclosed List of Resources.

Thank you.

<Plan Name>

[*The plan must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.*]

[*The plan is subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*https://www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call [*insert Participant Services toll-free phone and TTY numbers and days and hours of operation*]. The call is free.

The State of New York has created a Participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800) or online at [icannys.org](http://icannys.org/).

**List of Resources**

| **Resources** | Information |
| --- | --- |
| **<Plan Name>**  For questions about your plan coverage | Call: <toll-free number>  TTY users: <toll-free TTY number>  <days and hours of operation>  The call and the help are free.  Online: <website> |
| **New York Medicaid Choice**  For questions about the FIDA-IDD program and your Medicaid benefits | Call: 1-844-343-2433  TTY users: 1-888-329-1541  A free interpreter: 1-855-600-3432  Monday-Friday, 8:30 am – 8:00 pm  Saturday, 10:00 am – 6:00 pm  The call and the help are free.  Online: <http://www.nymedicaidchoice.com> |
| **Medicare**  For questions about your Medicare benefits | Call: 1-800-MEDICARE (1-800-633-4227)  TTY users: 1-877-486-2048  24 hours a day, 7 days a week  The call and the help are free.  Online: [www.medicare.gov](https://www.medicare.gov/) |
| **Independent Consumer Advocacy Network (ICAN)**  For questions about your rights | Call: 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800)  A free interpreter: 1-844-614-8800  Monday-Friday, 8:00 am – 8:00 pm  The call and the help are free.  Online: [www.icannys.org](http://icannys.org/) |