



STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

NOTICE OF DISMISSAL - WITHDRAWAL

Notice Date: September 24, 2014

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000000777

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On July 31, 2014, you requested an appeal regarding the July 31, 2014 preliminary eligibility determination made by the Marketplace. A notice of that preliminary determination was issued on August 1, 2014. That determination stated that you remained eligible for Emergency Medicaid coverage and that your coverage under Emergency Medicaid will begin June 1, 2014.

On August 8, 2014, the Marketplace issued an eligibility redetermination in your case. That determination stated that you were conditionally eligible for Medicaid and your coverage under Medicaid will begin August 1, 2014.

On September 8, 2014, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. At that hearing, you testified that you were satisfied with your current eligibility determination and had spoken with the Customer Service Unit on Friday, September 5, 2014, to withdraw your appeal. You also testified that you no longer wished to continue your appeal. Under sworn testimony, you withdrew your hearing request on the record.

Accordingly, we are dismissing your appeal.

How does this Dismissal Affect My Eligibility?

Your appeal request of the July 31, 2014 preliminary eligibility determination is dismissed in accordance with your request.

The August 1, 2014 eligibility determination remains unchanged. The subsequent August 8, 2014 eligibility determination remains in effect.

If You Think Your Appeal Should Not Be Dismissed

If you think your appeal should not be dismissed, you can ask us to vacate (cancel) this dismissal. You must ask us in writing within 30 days after the date on this notice.

The Marketplace's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, the Marketplace will tell you in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed, and the Marketplace will take no further action on your appeal.

Appeal Identification Number

When communicating with the Marketplace about this appeal, please reference Appeal Identification Number AP000000000777.

How to Contact the Marketplace

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.530.

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This Notice Has Been Provided To:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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