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

# NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: January 16, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000001115

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On November 24, 2014, you requested an appeal regarding the November 24, 2014 preliminary eligibility determination made by the Marketplace. That preliminary eligibility determination stated that your son, [REDACTED] was not eligible for financial assistance.

On December 6, 2014, an eligibility determination notice was issued. The notice stated that [REDACTED] was eligible to enroll in qualified health plan (QHP). However, he did not qualify for Child Health Plus or Medicaid because federal and state data sources showed that he was already enrolled in Medicaid, Child Health Plus, or another program.

On December 17, 2014, you were scheduled to appear for a telephone hearing. A Hearing Officer from the Marketplace's Appeals Unit called you to conduct the hearing. At the hearing, you testified that [REDACTED] had received a Medicaid card from your Local Department of Social Services and that he had been able to use the card at your local hospital. You requested that your appeal with the Marketplace be withdrawn because your son already obtained medical coverage through the Local Department of Social Services.

Accordingly, we are dismissing your appeal, pursuant to 45 CFR § 155.530(a)(1).

## How does this Dismissal Affect My Eligibility?

Your appeal of [REDACTED] December 6, 2014 eligibility determination is dismissed pursuant to your telephonic request.

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: 1-877-622-4886).).

The December 6, 2014 eligibility determination finding [redacted] eligible to enroll in a QHP but not eligible for Child Health Plus or Medicaid because federal and state data sources show that he is already enrolled in Medicaid, Child Health Plus, or another program, is now final.

## 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 AP000000001115.

## 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

## 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

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