



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

## NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: January 27, 2015

New York State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000001133

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

Dear [REDACTED],

On November 19, 2014, the Marketplace received your appeal regarding the November 7, 2014 eligibility determination issued by the Marketplace. That determination stated that you were not eligible to enroll in health coverage through NY State of Health because you did not provide documentation to verify your citizenship status.

On December 23, 2014, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. At that hearing, you testified that you no longer wished to continue your appeal because you had been enrolled in health coverage through the Marketplace under a duplicate account. You further testified that you were satisfied with your current eligibility determination in the duplicate account, which found you eligible to enroll in a qualified health plan. You confirmed that you enrolled in the Empire Blue Cross Blue Shield Platinum Plan and did not want Medicaid.

You requested the account on appeal closed since your coverage is effective through your duplicate account.

Under sworn testimony, you verbally withdrew your hearing request on the record.

Accordingly, we are dismissing your appeal.

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).

## **How does this Dismissal Affect My Eligibility?**

Your appeal request of the November 7, 2014 eligibility determination is dismissed in accordance with your verbal request.

This dismissal does not affect your current eligibility determination issued in your duplicate account.

## **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 refer to the Appeal Identification Number at the top of this notice.

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

## **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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