



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

NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: January 27, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000001147

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

Dear [REDACTED],

On December 5, 2014, you spoke with the Marketplace's Accounts Review Unit who created an appeal request on your behalf regarding the November 15, 2014 disenrollment notice for [REDACTED] issued by the Marketplace. That notice stated that [REDACTED] would be disenrolled from his health insurance plan effective November 30, 2014.

On December 29, 2014, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. At that hearing, you testified that you did not request a hearing but one was scheduled by the Marketplace's Account Review Unit. You further testified that you had enrolled [REDACTED] in MetroPlus Health Plan effective January 1, 2015. During the hearing, the Hearing Officer confirmed that [REDACTED] account reflected his enrollment in MetroPlus Health Plan effective January 1, 2015. You then stated that you no longer wished to continue with the appeal because [REDACTED] was already enrolled in health coverage effective January 1, 2014.

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

Accordingly, we are dismissing your appeal.

How does this Dismissal Affect My Eligibility?

The appeal request of the November 15, 2014 disenrollment notice is dismissed in accordance with your verbal request.

This dismissal does not affect [REDACTED] current eligibility determination or enrollment status. [REDACTED] remains enrolled in MetroPlus Health Plan effective January 1, 2015.

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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