



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

NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: February 17, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000001185

[REDACTED]
[REDACTED]
[REDACTED]

Dear Ms. [REDACTED],

On December 15, 2014, you requested an appeal regarding the November 5, 2014 eligibility determination made by the Marketplace. That eligibility determination stated that you were not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost sharing reductions. You were also not eligible to enroll in a qualified health plan at full cost through the Marketplace. The notice further stated that you did not provide information proving your citizenship status in order to confirm your eligibility for any of the above programs.

On November 18, 2014, you faxed a copy of your United States of America passport to the Marketplace.

On December 3, 2014, a copy of the fax, including a copy of your passport, was uploaded to your Marketplace account. The passport was verified by the Marketplace on December 8, 2014.

On December 9, 2014, an eligibility determination notice was issued. The notice stated that you were eligible to receive up to \$21.00 per month in advance premium tax credit, which could be applied to your monthly premium when you enroll in a qualified health plan for 2014.

You were subsequently enrolled in a plan for 2015.

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).

On January 5, 2015, you were scheduled to appear for a telephone hearing. A Hearing Officer from the Marketplace's Appeals Unit called you to conduct the hearing, with assistance from a [REDACTED] interpreter ([REDACTED]). At the hearing, you testified that you wished to withdraw your appeal because you were told that everything was already taken care of in regards to your insurance coverage.

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

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

How does this Dismissal Affect My Eligibility?

Your appeal of the November 5, 2014 eligibility determination is dismissed pursuant to your telephonic request.

The December 9, 2014 eligibility determination finding you eligible to receive up to \$21.00 per month in advance premium tax credit that you can apply to your monthly premium when you enroll in a qualified health plan 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 AP000000001185.

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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

[REDACTED]
[REDACTED]
[REDACTED]

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