



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

## NOTICE OF DISMISSAL - TELEPHONE WITHDRAWAL

Notice Date: February 9, 2015

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000001251

[REDACTED]  
[REDACTED]  
[REDACTED]

Dear [REDACTED],

On September 29, 2014, you uploaded a statement requesting to be considered for the Medicaid Premium Assistance Program to your Marketplace Account.

On October 1, 2014, the Marketplace issued a notice stating that the documentation submitted about your third party health insurance was insufficient. The notice requested more information to satisfy the documentation requirement of Employer Sponsored Health Insurance.

On that same day, you reapplied for health insurance through the Marketplace. The Marketplace prepared a preliminary eligibility determination finding that you are eligible for Medicaid. You also requested an appeal regarding the October 1, 2014, eligibility determination made by the Marketplace.

On January 26, 2015, you called the New York State of Health Appeals Unit to withdraw your appeal. A Hearing Officer from the Marketplace's Appeals Unit received your call and placed you under oath.

While under oath, you identified yourself and withdrew your appeal on the record. You stated that a representative from New York State of Health contacted you and stated that you were approved to receive Medicaid Premium Assistance Program payments.

You testified that you no longer wished to pursue 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).

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

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

The October 1, 2014, eligibility determination continues 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 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: 1-877-662-4886).

## **Legal Authority**

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.530(a)(1)(i)(B).

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**This Notice Has Been Provided To:**

[REDACTED]  
[REDACTED]  
[REDACTED]

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