



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: March 25, 2015

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000002067

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

Dear [REDACTED],

You applied for health insurance through the Marketplace for the 2015 tax year on March 9, 2015.

In an eligibility determination issued on March 10, 2015, the Marketplace found that you remained eligible for Medicaid.

On March 16, 2015, you requested an appeal of this determination insofar as your eligibility for coverage did not begin until April 1, 2015.

On March 20, 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 stated that you had been told that the problem with your enrollment had been corrected and that you were no longer interested in pursuing the appeal. You stated that you understood that in withdrawing your appeal, there would be no hearing and your appeal would not be reviewed by the Marketplace’s Appeals Unit.

Therefore, you withdrew your appeal on the record. Accordingly, we are dismissing your appeal, pursuant to 45 CFR § 155.530(a)(1).

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).

How does this Dismissal Affect Your Eligibility?

The March 1, 2015 effective start date for your Medicaid coverage will not be affected by the withdrawal of your appeal.

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 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

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Legal Authority

We are sending you this notice in accordance with federal regulation 45 CFR § 155.530.

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A Copy of this Notice of Dismissal Has Been Provided To

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

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