



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: July 10, 2015

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000002635

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On April 17, 2015, the Marketplace issued a disenrollment notice confirming that that your coverage under your Medicaid Managed Care (MMC) plan terminated effective April 30, 2015.

On April 28, 2015, you spoke with the Marketplace's Account Review Unit and appealed the April 17, 2015 disenrollment notice insofar as you would no longer be eligible for Medicaid coverage under your MMC plan as of April 30, 2015.

Between April 27, 2015 and June 2, 2015, the Marketplace received several applications.

On June 3, 2015, the Marketplace issued a notice of eligibility redetermination based on one of your June 2, 2015 applications. It stated that you were eligible for Medicaid beginning June 1, 2015.

On June 19, 2015, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit.

During the hearing, through sworn testimony, you stated that you wished to withdraw the appeal regarding your disenrollment from your MMC plan, as reflected in the April 17, 2015 notice, because you had subsequently been found eligible for Medicaid beginning June 1, 2015.

You therefore withdrew your appeal on the record.

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).

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

How does this Dismissal Affect Your Eligibility?

The Marketplace's April 17, 2015 disenrollment notice remains in effect.

Please note that the withdrawal of your appeal as reflected in this notification has no effect on any subsequent determinations issued by the Marketplace on or after April 17, 2015, including the June 3, 2015 eligibility determination finding you eligible for Medicaid beginning June 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 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

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.

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A Copy of this Notice of Dismissal Has Been Provided To

[REDACTED]
[REDACTED]
[REDACTED]

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