



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

NOTICE OF DISMISSAL – WRITTEN WITHDRAWAL

Notice Date: July 16, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000002813

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

On April 16, 2015, the Marketplace issued a notice of eligibility determination, stating that you are not eligible for retroactive Medicaid coverage from January 1, 2015 to January 31, 2015, because your household income of \$3,050.00 that month is over the allowable income limit of \$1,343.00 monthly. You appealed this determination.

On June 2, 2015, the Marketplace issued a Notice of Hearing to advise you that the hearing you requested was scheduled for July 7, 2015 at 1:00 p.m.

On July 2, 2015, you uploaded an executed written letter noting that you were withdrawing your appeal and requesting that the hearing of July 7, 2015 be cancelled. Accordingly, your withdrawal is accepted, your appeal is dismissed, and the hearing scheduled for July 7, 2015 is cancelled.

How does this Dismissal Affect My Eligibility?

The Appeals Unit of NY State of Health will not be reviewing 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. In that writing, explain why you did not appear for your hearing as scheduled.

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

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulations 45 CFR § 155.530.

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).

A Copy of this Notice of Dismissal Has Been Provided To:

[REDACTED]
[REDACTED]
[REDACTED]

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).