



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: July 8, 2015

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000002888

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

Dear [REDACTED],

On May 12, 2015, the Marketplace received your two applications for health insurance. The first application resulted in the Marketplace preparing a preliminary eligibility determination that stated you were eligible to receive an advance premium tax credit of up to \$0.00 per month.

Also on May 12, 2015, you spoke to the Marketplace's Account Review Unit and appealed that preliminary determination insofar as it did not approve an advance premium tax credit of more than \$0.00 per month.

Also on May 12, 2015, the Marketplace received your second application for health insurance.

On May 13, 2015, the Marketplace issued a notice of eligibility redetermination based on your second application that stated you were conditionally eligible for Medicaid effective May 1, 2015.

On June 19, 2015, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. You testified that you are satisfied with your current eligibility determination. You further testified that you no longer wished to continue with the appeal.

Under sworn testimony, you verbally withdrew your hearing request 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: 1-877-622-4886).

Accordingly, we are dismissing your appeal.

How does this Dismissal Affect My Eligibility?

The Appeals Unit will not be reviewing this matter.

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: 1-877-622-4886).

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] [REDACTED] [REDACTED]
[REDACTED]

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