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

NOTICE OF DISMISSAL – WRITTEN WITHDRAWAL

Notice Date: February 1, 2016

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000004995

[redacted]

Dear [redacted],

On October 3, 2015, the Marketplace issued a notice of eligibility determination stating that you were conditionally eligible for Medicaid, effective October 1, 2015. On October 23, 2015, you appealed not being able to select a Medicaid Managed Care (MMC) plan due to your conditional eligibility.

Thereafter, you submitted the requisite documents confirming your household's income and your immigration status.

On December 16, 2015, the Marketplace issued a notice of telephone hearing for a scheduled hearing on January 29, 2016 at 9:00 a.m.

On December 18, 2015, the Marketplace issued an enrollment notice confirming your Medicaid Managed Care (MMC) plan selection with an effective start date of January 1, 2016.

On January 13, 2016, a copy of your January 3, 2016 written withdrawal of your appeal and request to cancel the scheduled hearing was uploaded to your Marketplace account (Document [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: 1-877-662-4886).).

Based on your January 3, 2016 written request to withdraw your appeal and cancel the scheduled hearing, we are dismissing your appeal, pursuant to Code of Federal Regulation (CFR) 45 CFR § 155.530(a)(1).

How does this Dismissal Affect Your Eligibility?

The Appeals Unit of NY State of Health will not be reviewing this matter at this time.

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 45 CFR § 155.530.

A Copy of this Notice of Dismissal Has Been Provided To

[redacted]

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