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

# NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: March 1, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000005378

[redacted]

Dear [redacted],

On November 22, 2015, NY State of Health issued a disenrollment notice stating in part that your spouse would be disenrolled from her Medicaid Managed Care (MMC) plan, effective November 30, 2015. On December 5, 2015, NY State of Health issued a notice of eligibility determination stating in part that your spouse was eligible for Medicaid, effective December 1, 2015. That same day, NY State of Health issued an enrollment notice stating in part that your spouse's MMC plan would take effect on January 1, 2016. You appealed your spouse not being able to be enrolled in her MMC as of December 1, 2015.

On December 22, 2015, NY State of Health granted your request for aid to continue for your spouse during the appeal process and backdated her MMC start date to December 1, 2015.

On February 25, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called you and placed you under oath.

While under oath, you identified yourself and stated that you were no longer interested in pursuing your appeal because you were satisfied that your spouse had uninterrupted coverage in her MMC plan throughout December 2015.

You therefore withdrew your appeal on the record. Accordingly, we are dismissing your appeal, pursuant to 45 Code of Federal Regulations (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 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, or 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

## Legal Authority

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

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

[redacted]

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