



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: February 26, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000005581

[REDACTED]

Dear [REDACTED],

On December 17, 2015, NY State of Health issued a notice of eligibility determination stating that your son was eligible to enroll in Child Health Plus (CHP) at no cost, effective January 1, 2016. You appealed that determination insofar as the Marketplace did not backdate his coverage to December 1, 2015.

On February 24, 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 of the passage of time and you did not incur any medical expenses for your son in 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).

The Hearing Officer agreed to confirm your children's enrollment dates in their CHP plan. Their respective enrollments are as follows:

[REDACTED] Market Place ID: [REDACTED]

CHP Plan Code: [REDACTED] Plan: UnitedHealthcare Community Plan
Enrollment Start Date: 08/01/2015 Enrollment End Date: 11/30/2015

CHP Plan Code: [REDACTED] Plan: UnitedHealthcare Community Plan
Enrollment Start Date: 01/01/2016 Enrollment End Date: 12/31/2016

[REDACTED] Market Place ID: [REDACTED] :

CHP Plan Code: [REDACTED] Plan: UnitedHealthcare Community Plan
Enrollment Start Date: 08/01/2015 Enrollment End Date: 07/31/2016(Obsolete)

CHP Plan Code: [REDACTED] Plan: UnitedHealthcare Community Plan
Enrollment Start Date: 08/01/2015 Enrollment End Date: 12/31/2016

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

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).

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



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