



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

## NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: May 12, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000005618

[REDACTED]

Dear [REDACTED] and [REDACTED],

On December 16, 2015, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you [REDACTED] were eligible to purchase a qualified health plan at full cost, effective January 1, 2016, and not eligible for Medicaid because of being over the MAGI age limit. You appealed this determination.

On May 12, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called [REDACTED], your authorized representative, and placed him under oath.

While under oath, your authorized representative identified himself and stated that you were no longer interested in pursuing your appeal because you had obtained Medicaid through your county and were satisfied with this outcome.

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).

### 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 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).

## **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.

NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

## **Appeal Identification Number**

When communicating with NYSOH about this appeal, please reference Appeal Identification Number at the top of this notice.

## **How to Contact NYSOH**

You can contact us in any of the following ways:

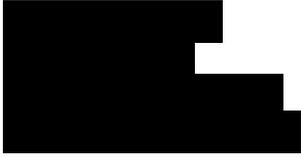
- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

## **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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