



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: April 28, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000005916

[REDACTED]

Dear [REDACTED],

On December 7, 2015, you contacted NY State of Health (NYSOH) to disenroll your spouse from her coverage and, as a result, your child was systematically disenrolled from her Child Health Plus (CHP) plan in error, effective December 31, 2015. On January 3, 2016, NYSOH issued notices of eligibility determination and enrollment confirmation stating that your child was eligible to enroll in CHP and was re-enrolled in her CHP plan, effective February 1, 2016. You appealed NYSOH's inability to correct its error and backdate your child's CHP enrollment start date to January 1, 2016.

On April 25, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called you and placed you under oath. At your request, the hearing was adjourned to April 26, 2016.

At the adjourned hearing on April 26, 2016, while still under oath, you identified yourself and stated that you were no longer interested in pursuing your appeal because you wanted to avoid any further disruption in your child's CHP coverage and, as such, were satisfied with the February 1, 2016 start date of her CHP enrollment.

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.

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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