



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

## NOTICE OF DISMISSAL

Notice Date: June 7, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000006596



Dear [REDACTED],

On December 6, 2015 New York State of Health (NYSOH) issued an enrollment notice confirming that your newborn child was enrolled in Empire Blue Cross Blue Shield HealthPlus (Medicaid) with a plan enrollment start date of January 1, 2016. You appealed the plan enrollment start date of their plan.

On April 26, 2016, the NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for June 1, 2016 at 2:00 pm.

On June 1, 2016, a Hearing Officer from the NYSOH contacted you for your scheduled hearing. You requested an adjournment, and the hearing was rescheduled for June 1, 2016 at 4:00 pm.

On June 1, 2016, between 4:00 pm and 4:30 pm, a Hearing Officer from NYSOH contacted you at the telephone number you provided to NYSOH. On the Hearing Officer's third attempt you answered the telephone, however, the call was terminated when the Hearing Officer asked you to identify yourself for the record.

Accordingly, we are dismissing your appeal.

### **How does this Dismissal Affect My Eligibility?**

The Appeals Unit of NY State of Health will not review your appeal 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: 1-877-622-4886).

## **If You Think Your Appeal Should Not Be Dismissed**

If you think your appeal should not be dismissed, you can ask us to vacate (cancel) this dismissal. You must ask us in writing within 30 days after the date on this notice. In that writing, explain why you did not appear for your hearing as scheduled.

The 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, 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 refer to the 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 Code of Federal Regulations 45 CFR § 155.530.

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**A Copy of this Notice of Dismissal Has Been Provided To:**



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