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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: July 6, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000006991

[redacted]

Dear [redacted],

On February 3, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, stating that you were eligible to enroll in the Essential Plan, effective March 1, 2015. You appealed this determination insofar as you were seeking to have your Essential Plan coverage begin no later than January 1, 2016. Also on February 3, 2016, NYSOH issued a disenrollment notice stating that your qualified health plan (QHP) coverage with Healthfirst would end effective February 29, 2016. You appealed that notification insofar as you were seeking for your QHP coverage with Healthfirst to end effective January 1, 2016.

On June 30, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called you and placed you under oath. Your sister, [redacted], acted as your Authorized Representative during the appeal.

Your Authorized Representative, acting on your behalf, stated that you were no longer interested in pursuing your appeal because (1) you did not incur any out-of-pocket medical expenses during the months of January and February 2016, and (2) your NYSOH account enrollment details reflect that, as of February 3, 2016, your QHP coverage with Healthfirst was terminated effective January 1, 2016.

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 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 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

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).

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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