



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: July 18, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000007058

[REDACTED]

Dear [REDACTED],

On February 10, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, stating that you were not eligible for Medicaid June 1, 2015 through June 30, 2015. You appealed that determination.

On July 13, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called you and placed you under oath with aid of Mandarin interpreter # [REDACTED].

While under oath, you identified yourself and stated that you were no longer interested in pursuing your appeal because your medical bills which you wished to be covered under Medicaid for the month of June, 2015 had been paid for after you worked with a charity organization that provided you aid. You testified you did not require a hearing on the issue of your eligibility for Medicaid for the month of June, 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).

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.

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).

A Copy of this Notice of Dismissal Has Been Provided To



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