



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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: August 22, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000007693

[REDACTED]

Dear [REDACTED],

On March 5, 2016, New York State of Health (NYSOH) issued an enrollment notice confirming that on March 4, 2016, that you were enrolled in Medicaid (Fidelis Care) with a plan enrollment start date of April 1, 2016.

Also on March 5, 2016, NYSOH issued a notice confirming that on March 4, 2016, a request for a telephone hearing to review the start date of your Medicaid Managed Care plan was made.

On August 17, 2016, you had a scheduled telephone hearing with NYSOH's Appeals Unit. You were contacted by a Hearing Officer with NYSOH's Appeals Unit and authorized [REDACTED] as your appeal representative. The Hearing Officer contacted your representative to conduct the hearing. Your representative confirmed that the issue was moot and withdrew your appeal on the record through sworn testimony.

Accordingly, we are dismissing your appeal.

How does this Dismissal Affect Your Eligibility?

The Appeals Unit of NY State of Health will not review your appeal at this time.

This dismissal will not affect any determinations made after the appeal request.

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

Under some circumstances, 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 you also must state a good reason for us to do this.

If you ask us in writing to vacate this dismissal, NYSOH's Appeals Unit will review your request and send you a decision on that request.

If we deny your request to vacate this dismissal, we will tell you that in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed. No further action will be taken on it by the Marketplace.

Appeal Identification Number

When communicating with the Marketplace about this appeal, please reference 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 Federal regulation 45 CFR § 155.530.

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A Copy of this Notice of Dismissal Has Been Provided To

[REDACTED]

[REDACTED]

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