



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

## NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: September 09, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000007723

[REDACTED]

Dear [REDACTED],

On February 19, 2016, NY State of Health (NYSOH) issued an enrollment confirmation notice stating you and your spouse's enrollment in the Essential Plan would begin April 1, 2016. You appealed that notice.

On September 1, 2016, a Hearing Officer from the Appeals Unit of NY State of Health called you and placed you under oath.

While under oath, you identified yourself and stated that you were no longer interested in pursuing your appeal on the issue of the start date of you and your spouse's enrollment in the Essential Plan. You testified that you had been more concerned with the issue of your spouse being disenrolled due to an error on the part of your application counselor in selecting whether she was a U.S. Citizen, or naturalized citizen, causing her disenrollment for the month of July, 2016. You explained that the issue had been resolved, and both you and your spouse had now been enrolled in a qualified health plan. You testified you were unsure what, if anything you would be seeking to appeal at this point in time. You then testified you needed to be somewhere else and could not continue with an appeal hearing and no longer wanted a hearing on the issues discussed.

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

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## **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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