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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: April, 22 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000008656

[redacted]

Dear [redacted],

According to your NY State of Health (NYSOH) account, you had health insurance coverage through Medicaid Fee-For-Service from February 1, 2015 to January 31, 2016.

On February 3, 2016, NY State of Health (NYSOH) issued notices of eligibility redetermination and enrollment that stated you were eligible for and enrolled in the Essential Plan with Fidelis Care, effective March 1, 2016.

On April 5, 2016, NYSOH issued another enrollment notice confirming that you were enrolled in the Essential Plan 1 with Fidelis Care with a plan enrollment start date of March 1, 2016, and Delta Dental Basic Dental with a plan enrollment start date of March 1, 2016. However, NYSOH made your enrollment start date in your dental plan effective May 1, 2015, from which you requested an appeal.

On April 6, 2016, NYSOH redetermined your eligibility based on your updated application of that date and found you preliminarily eligible for Medicaid, effective April 1, 2016.

Also on April 6, 2016, NYSOH issued a disenrollment notice informing you that your 2016 Essential Plan 1 coverage would end effective April 30, 2016. The

notice further stated that you would be sent a separate notice confirming your new coverage information shortly.

On April 7, 2016 consistent with its April 6, 2016 preliminary redetermination, NYSOH issued a notice of eligibility redetermination that stated you were eligible for Medicaid, effective April 1, 2016.

Also on April 7, 2016, NYSOH issued a notice of eligibility determination regarding your request for retroactive Medicaid to help pay for medical bills for three months prior to April 1, 2016. That notice stated that you were eligible for Medicaid for March 1, 2016 through March 31, 2016, because your monthly household income of $531.25 was at or below the allowable monthly income limit of $1,843.00 for Medicaid. The notice further stated that additional income information was required in order to determine your eligibility for the time period of January 1, 2016 to February 29, 2016 by April 21, 2016.

Also on April 7, 2016, NYSOH issued an enrollment notice confirming your Medicaid Managed Care (MMC) plan selection with Fidelis Care and your MMC plan enrollment start date of May 1, 2016.

On April 15, 2016, NYSOH issued a letter informing you that additional information is required to confirm your income for the month of February 2016 to determine your eligibility for retroactive Medicaid coverage that month.

On April 20, 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 because of the following reasons:

(1) You had active health insurance coverage in January 2016 through Medicaid Fee-For-Service so you do not qualify for retroactive Medicaid coverage that month;

(2) You did not have any medical bills in February 2016 and are not seeking retroactive Medicaid for that month;

(3) Your Fidelis Care Essential Plan 1, which began March 1, 2016, was accepted for treatment and services in March 2015 and so far in April 2015 and coverage in that plan continues through April 30, 2016;

(4) You were deemed eligible for retroactive Medicaid Fee-For-Services from March 1, 2016 to March 31, 2016 as supplemental coverage to your Essential Plan coverage;

(5) You became Medicaid eligible as of April 1, 2016 as supplemental coverage to your Essential Plan coverage, which will effectively end April 30, 2016; and,

(6) Your Fidelis Care MMC plan will begin on May 1, 2016, such that you have no gap in coverage and have continuing coverage going forward.

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 and no further action by NYSOH is required regarding your request for retroactive Medicaid coverage for the month of February 2016.

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.

A Copy of this Notice of Dismissal Has Been Provided To

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).