



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

## **NOTICE OF DISMISSAL – WRITTEN WITHDRAWAL**

Notice Date: November 15, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000009181

[REDACTED]

Dear [REDACTED]

On April 21, 2016, New York State of Health (NYSOH) issued a cancellation notice stating that your Medicaid fee-for-service coverage would be discontinued as of May 1, 2016.

On April 22, 2016, you faxed an appeal request to NYSOH insofar as the discontinuance of your Medicaid fee-for-service coverage.

On October 25, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for November 10, 2016 at 1:00 pm.

On November 3, 2016, [REDACTED] faxed a letter to NYSOH requesting that your appeal request be withdrawn.

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 Think Your Appeal Should Not Be Dismissed**

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).

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 NYSOH.

## **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 Federal regulation 45 CFR § 155.530.

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**A Copy of this Notice of Dismissal Has Been Provided To**



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