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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: November 23, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000009319, AP000000009602

[redacted]

Dear [redacted]

On December 21, 2015, NY State of Health (NYSOH) issued an eligibility determination notice stating that you and your spouse were newly eligible to purchase a qualified health plan (QHP) at full cost, effective January 1, 2016.

On April 19, 2016, NYSOH issued an eligibility redetermination notice, stating that your children were found eligible for Child health Plus (CHP) with a $9.00 monthly premium each, effective June 1, 2016.

You appealed the findings under the December 21, 2015 and April 19, 2016 eligibility determination notices.

On November 21, 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 of the December 21, 2015 eligibility determination notice since you intended now to seek to reconcile your lack of tax credit received between the months of January and May 2016 on your 2016 income tax return. You also stated that you were no longer interested in pursuing your appeal of the April 19, 2016 eligibility determination notice since you had not incurred any out-of-pocket medical expenses for your children between April 1, 2016 and May 31, 2016.

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).).

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.

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A Copy of this Notice of Dismissal Has Been Provided To

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