



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

## NOTICE OF DISMISSAL

Notice Date: December 9, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000011921

[REDACTED]

Dear [REDACTED],

On September 8, 2016, NY State of Health (NYSOH) issued an enrollment notice, stating that your Medicaid Managed Care (MMC) plan coverage would begin effective October 1, 2016. You appealed insofar as you were seeking for your MMC coverage to begin no later than September 1, 2016.

On November 18, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for December 7, 2016, at 1:00 p.m.

A Hearing Officer called you at 1:00 p.m. and 1:15 p.m. on December 7, 2016. You answered the second call attempt and stated that you no longer wanted to proceed with the appeal since your MMC plan coverage took effect as of October 1, 2016. The Hearing Officer asked to swear you in, in order to obtain a proper withdrawal over the telephone. You stated again that you did not want to proceed with the appeal and to just terminate the hearing.

Since your hearing did not go forward as scheduled, we are dismissing your appeal.

### **How does this Dismissal Affect My Eligibility?**

The Appeals Unit of NYSOH will not review your appeal at this time.

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: 1-877-622-4886).

## **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 of the date on this notice. In that writing, you must explain why your hearing did not go forward as scheduled.

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 refer to both the Appeal Identification number and the NY State of Health number at the top of this notice.

## **How to Contact NYSOH**

You can contact NYSOH 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 Code of Federal Regulations § 155.530.

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



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