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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: March 09, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013927

[redacted]

Dear [redacted]

On December 10, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, stating that your child was no longer eligible for Medicaid, however, his coverage would continue until May 31, 2017. The notice stated this was because certain individuals who qualified for Medicaid get coverage for twelve continuous months from the date they were last determined eligible. The notice stated you would have to come back between April 16, 2017 and May 15, 2017 to updated the information in your account. The determination was effective December 1, 2016 You appealed that determination.

On March 6, 2017, 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 you had found a physician in your area that you have been taking your child to and who now accepts your child's Medicaid coverage.

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

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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