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

NOTICE OF DISMISSAL – TELEPHONE WITHDRAWAL

Notice Date: March 22, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014248

[redacted]

Dear [redacted]

On December 14, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, stating that you remain eligible for Medicaid coverage for the treatment of emergency medical conditions only. The eligibility was effective December 1, 2016. You appealed this determination.

On February 20, 2017, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for March 13, 2017, at 3:00 p.m.

On March 13, 2017, a Hearing Officer from the Appeals Unit of NY State of Health called you with the aid of Korean Interpreter [redacted], and placed you under oath. While under oath, you testified that you needed more time to prepare for your hearing and speak with your Broker. You further testified you believed the hearing notice stated your hearing would be on March 17, 2017 at 3:00 p.m., not March 13, 2017 at 3:00 p.m. The Hearing Officer granted your adjournment request to March 17, 2017 at 3:00 p.m.

On March 17, 2017, a Hearing Officer from the Appeals Unit of NY State of Health Called you with the aid of Korean Interpreter [redacted]. While under oath, you identified yourself and testified you were no longer interested in pursuing your appeal because you had spoken with your Broker and determined you no longer required a hearing on your eligibility. You explained you recently were determined eligible for the Essential Plan 4 effective March 1, 2017. You testified

that you understood this recent determination was still only conditional and that you needed to provide acceptable proof of your immigration status by May 16, 2017. You then testified you still wished to withdraw your appeal.

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

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 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

[redacted]

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).