Form Approved
OMB No. 0960-0695

Appeal of Determination for Extra Help with Medicare Prescription Drug Plan Costs

FOR OFFICIAL USE ONLY

Date received:

Office code: ☐☐☐ Request filed late: ☐

1. Applicant's Name:

_____

2. Social Security Number:

_____

3. Medicare Number (the number is printed on your Medicare card):

_____

4. Spouse's Name (if spouse lives at same address as you):

_____

5. Spouse's Social Security Number (if spouse lives at same address as you):

_____

6. Spouse's Medicare Number (if spouse lives at same address as you):

_____

7. Please explain why you disagree with our decision:

_____

8. Do you have additional information to support your appeal?

☐ **YES (**Send the additional information with this form to the address shown on the bottom of page 2).

☐ **NO**

9. Do you want a hearing? If you have a hearing, it will be by telephone.

☐ **YES (**You will receive a notice with the date and time of the hearing. Please complete questions 10 through 13).

☐ **NO (**You will receive a decision based on the information available and any additional information you provide).

10. To give you time to prepare for the hearing, we allow at least 20 days between the date of your request and the date we schedule the hearing. Do you want a hearing sooner if scheduling permits?

☐ **YES**

☐ **NO**

11. Do you need an interpreter?

☐ **YES** (Specify language): _____

☐ **NO**

12. Are you hearing impaired?

☐ **YES**

☐ **NO**

13. Will you have other people at the hearing?

☐ **YES**

☐ **NO**

If **YES**, will you and the other people need to talk to us from more than one telephone number?

☐ **YES** We call this a conference call. When we send you the notice with your hearing date and time, we will also give you a telephone number and additional instructions for this conference call.

☐ **NO**

Please return your completed appeal form, including the signature page, and any additional information to:

Social Security Administration
Wilkes-Barre Direct Operations Center
P.O. Box 1030
Wilkes-Barre, PA 18767-1030

Signatures

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true to the best of my knowledge. I understand that making a false statement is a crime punishable under Federal law. By submitting this appeal, I am authorizing the Social Security Administration to obtain and disclose information related to my income resources and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, benefits, and pensions.

Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.

SECTION A

Your Signature:		Phone Number: ( ) _____ - _____
Your Home Street Address:		Apt. #:
City:	State:	ZIP Code:
Your Mailing Street Address (if different from home address):		Apt. #:
City:	State:	ZIP Code:

If you recently changed your address, put an X here: ☐

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

Print First Name:	Print Last Name:	Phone Number: ( ) _____ - _____

SECTION B

If someone assisted you, place an X in the box that describes that person and provide the rest of the information requested below.

☐ Family Member ☐ Attorney ☐ Advocate ☐ Other Specify: _____

☐ Friend ☐ Agency ☐ Social Worker

Print First Name:	Print Last Name:	Phone Number: ( ) _____ - _____
Address:		Apt. #:
City:	State:	ZIP Code:

Privacy Act Statement
Collection and Use of Personal Information

Section 1860 D-14 of the Social Security Act, as amended, allows us to collect this information which we will use to review and re-determine if you are eligible for a Medicare Part D subsidy. Providing this information is voluntary, but not providing this information may prevent us from determining your eligibility for a Medicare Part D subsidy. As law permits, we may use and share the information you submit, including with other Federal agencies, contractors, and others, as outline in the routine uses within System of Record Notices 60-0090, 60-0310, and 60-0321, available at www.ssa.gov/privacy. Your information may also be used in computer matching programs for Federal benefits eligibility and to recoup debts under these programs.

Paperwork Reduction Act Statement — This information collection meets the requirements of 44 U.S.C. §3507, as amended by section 2 of the *Paperwork Reduction Act of 1995*. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: Social Security Administration, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***