DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

RESPONSE TO NOTICE OF HEARING

You must send this Response to the Office of Medicare Hearings and Appeals (OMHA) within 5 days of receiving the Notice of Hearing.

TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS

ALJ Appeal Number	Appellant type *(check one)*
	☐ Beneficiary ☐ Provider ☐ Supplier ☐ Medicaid State Agency

Beneficiary Name *(Leave blank if same as party name)*	Health Insurance Claim (HIC) Number

Provider or Supplier *(if different from appellant)*

Hearing Scheduled for:

Day of Week	Date	Time
	____ / ____ / 20____	

Type of Hearing	Location *(if applicable)*
☐ Video-Teleconference ☐ Telephone ☐ In-Person	

Street Address	City

State	ZIP Code	Administrative Law Judge (ALJ) assigned to hear the Appeal

Call-in number and password *(if applicable)*

TO BE COMPLETED BY THE RECIPIENT OF NOTICE OF HEARING

Recipient Name	Street Address	
City	State	ZIP Code
Telephone Number	Alternate Telephone Number	
( )	( )	
FAX Number	E-Mail	
( )		

Recipient's Representative *(if applicable)*	Street Address	
City	State	ZIP Code
Telephone Number	Alternate Telephone Number	
( )	( )	
FAX Number	E-Mail	
( )		

Recipient or Representative Signature	Date

Check only one item below:

Item 1a. ☐ **I will be present at the time and place shown on the Notice of Hearing.** If an emergency arises after I mail this Response and I cannot be present, I will immediately notify you at the telephone number shown on the Notice of Hearing in the letterhead.

Item 1b. ☐ **I cannot be present at the time and place shown on the Notice of Hearing.** I understand that the ALJ has the discretion to change the time and place of the hearing as long as my explanation for the request meets the good cause standard for changing the time and place of the hearing. (An example of good cause would be a serious physical condition or death in the family.) I would like to reschedule my hearing for the following date and time and I have good cause to reschedule my hearing because: *(Please attach a sheet of paper if you need more room.)*

Item 1c. ☐ I want to waive my right to an ALJ hearing. I understand it is my right to have a hearing. I want to waive my right to a hearing because: *(Please attach a sheet of paper if you need more room.)*

For the three items below, only check the items if applicable:

Item 2. ☐ **I object to the type of hearing scheduled.** I understand that the ALJ assigned to the appeal, with the agreement of the Managing ALJ of the OMHA Field Office hearing my appeal, has the discretion to change the type of the hearing scheduled as long as my explanation for the objection meets the good cause standard. (An example of good cause would be that the case presents complex, challenging, or novel presentation of issues that necessitate an in-person hearing.) I want an in-person hearing because: *(Please attach a sheet of paper if you need more room.)*

Item 3. ☐ **I object to the issues described in the Notice of Hearing.** I understand that the ALJ assigned to my appeal will make a decision on my objection to the issues either in writing or at the hearing, on the record. I object to the issues described in the Notice of Hearing because: *(Please attach a sheet of paper if you need more room.)*

Item 4. ☐ **I object to the ALJ assigned to my appeal.** I understand that the ALJ may reject my disqualification request because the ALJ does not believe his or her participation in the appeal would give an appearance of impropriety. The ALJ must disqualify himself or herself from adjudicating a case if the ALJ is prejudiced or partial with respect to any party or has an interest in the matter pending for decision. The ALJ may disqualify himself or herself from adjudicating a case if the ALJ believes his or her participation in the case could give an appearance of impropriety. I object to the ALJ because: *(Please attach a sheet of paper if you need more room.)*

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(h)(I), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.