

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

REQUEST FOR COPY OF RECORD(S): THIRD-PARTY WITH THE INDIVIDUAL APPELLANT'S CONSENT

This form is only applic	eable to third-parties v	with conse	ent from the	indiv	idual appellar	nt. ————————————————————————————————————
I, the Office of Medicare Hearing the appellant to have copies			, am ealth and Hum	reque nan S	esting a copy of ervices. I have	of the following record(s) from received written consent from
Please check if applicable:	I am requesting a	a copy of the	e entire record	1	I am request	ting a partial copy of the
	sting a copy of the enti	ire record, _I	please specify	belo	w in detail the	record(s) you are requesting. lease attach another sheet of
Please provide the informa	tion for the appellant i	f available:				
Name				ALJ Appeal Number		
Health Insurance Claim (HIC) Number Soc			curity Number			Date of Birth
Please check if applicable: The requested record(s) wi	I have already re			ord(s)	I am requestinç	<u> </u> g.
Street		J * * * * * *			City	
State	Third-Party's Pho			one Number		
)		
the form entitled "Individual Appell The consent must be signed and portion. If you are only authorized	ant's Consent to Third-Party dated by both you and the i d to have access to a porti	for Copies on the formal of the consecution of the consecution.	izes you to have f the Individual A ellant and must ent must specify	Appella specify which	int's Record(s)," H whether you hav record(s). The co	I appellant's record(s). You should use IHS-721, to satisfy these requirements are access to the entire record or only a consent must also specify whether an written consent notarized by an official
		HOW TO CA	LCULATE FEES	3		
susceptible to photocopying is as exceeds \$25, the requesting party	sessed at actual cost. No will be charged in full. The (nerwise specified if we dete	charge will be Office of Medie	e made if the to care Hearings ar	otal am nd App	nount of copying one in the copying of the copying	ts per page and copying of records not does not exceed \$25. If the total cos send you an invoice to the address you g. The OMHA will send the requested
The OMHA will make every e	ffort to deliver a copy of	the reques	ted records be	efore	the date of the	hearing.
		PRIVACY AC	CT STATEMENT	•		
The legal authority for the colle	ction of information on the				1 Security Act (s	ection 1155 of Title XI and section

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. The Social Security Number will be used to verify the identity of the individual appellant. 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.

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