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 (if different from Social Security number):

_____

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 different from Social Security number and 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 provided.

10. To give you time to prepare for the hearing, we must 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**

☐ **NO**

If **YES**, we call this a conference call. When we send you the notice scheduling the hearing, we will give you a telephone number to use for this conference call and additional instructions for setting up this call.

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

Social Security Administration
Wilkes-Barre Data 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 you are helping someone to complete this form, 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 you are assisting someone else, place an X in the box that describes who you are and provide your daytime phone number and address.

☐ 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 / Paperwork Reduction Notice

Section 1860 D-14 of the Social Security Act, as amended, authorizes us to collect this information. The information you provide will be used to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan.

The information you furnish on this form is voluntary. However, failure to provide this requested information could prevent an accurate and timely decision on your appeal.

We rarely use the information you supply for any purpose other than for making a determination about your continuing entitlement to benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notice entitled Medicare Database (60-0321). This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at **www.socialsecurity.gov** or at your local Social Security office.

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, 1338 Annex Building, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**