Added the button seal, the swish and Extra in the title

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.

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.

10. 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
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 SSA 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: (_____) _____ — _____

Street Address:	Apt. #:

City:	State:	Zip Code:

Privacy Act / Paperwork Reduction Notice

Section 1860 D-14 of the Social Security Act authorizes the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan. You do not have to give us the information requested. However, if you do not provide the information, we will be unable to make an accurate and timely decision on your appeal. We may provide information collected on this form to another Federal, State, or local government agency to assist us in determining your eligibility for the subsidy or if a Federal law requires the release of information. We also may need to share the information with other SSA programs if SSA needs to determine your eligibility in those programs.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any 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.**