Social Security Administration
Office of Quality Performance

(Address of Office)
Date:
Beneficiary:
SSN:

(Address)

The Social Security Administration is contacting a few people who have applied for extra help with Medicare prescription drug plan costs. We are doing a quality review to make sure we made the correct decision on these applications. We picked (**fill-in 1**) name by chance, **NOT** for any other reason. To make sure we made the correct decision on (**fill-in 2**) application, I would like you to telephone me at my office on (**fill-in 3**). For general information about Social Security or to verify that this is an official communication, you can call our national toll-free number at 1-800-772-1213.

IMPORTANT INFORMATION
You do not have to give us the requested information. However, if you do not provide the information, we will not be able to evaluate if the denial of your request for extra help with Medicare prescription drug plan costs was correct. The Social Security law that allows us to ask you questions is explained in the enclosed page, Privacy Act and the Paper Reduction Act Notice.

WHAT WILL HAPPEN WHEN YOU CALL
I will identify myself by name as shown at the bottom of this letter. I will ask you some questions about the information given on (**fill-in 4**) application for help with Medicare prescription drug plan costs.

HOW YOU CAN GET READY FOR YOUR CALL
I have enclosed a page that shows the kinds of information you should have ready. I have checked the things I would like to talk about. If you do not have all of the information that I am requesting, I can help you get the information you do not have. If you would like to have a friend or relative help you, please tell that person to be there when you call.

PLEASE RETURN THE ENCLOSED FORM
I have enclosed an acknowledgement form for you to complete, sign and mail back to me in the envelope I have provided. You do not need to put a stamp on the envelope. This form is to let me know you received the letter and whether or not you will be able to call me.

If you have any questions, please call me at my office between 8:00 a.m. and 4:00 p.m., Monday through Friday. My toll-free number is 1-800- _____. Thank you for your help.

Sincerely,

Social Insurance Specialist

Enclosures

PRIVACY ACT AND PAPER REDUCTION ACT NOTICE

COLLECTION AND USE OF INFORMATION

See revised Privacy Act Statement below.

The Social Security Administration is authorized by ~~law~~ of the Social Security Act to collect the information requested in this interview. The information you give us, along with the information we get from other people we interview, helps us to know where there are problems in the programs for which the Social Security Administration is responsible. It also helps us to resolve these problems and recommend changes in the law.

You do not have to give us the requested information. However, if you do not provide the information, we will not be able to evaluate if the denial of your request for extra help with Medicare prescription drug plan costs was correct.

HOW THE INFORMATION IS USED

The information you provide may be disclosed to another Federal, State or local government agency for determining eligibility for a government benefit or program, to a Congressional office requesting information on your behalf, to an independent party for the performance of research and statistical activities, to the Department of Justice for use in representing the Federal Government, or if a Federal law requires that we give out this information.

We may also use this information 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. This law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide 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 section 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 15 minutes to read the instructions, gather the facts, and answer the questions. *Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-~~0001.~~* 6401

SSA will insert the following revised Privacy Act Statement into the form at its next scheduled reprinting:

Privacy Act Statement

Notice of Appointment - Denial

Section 1860 D-14 of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide, along with the information we receive from other people we interview, to conduct a quality review of applications and determine if we made the correct decision during the review process for those applicants who requested extra help with Medicare prescription drug costs.

The information you furnish on this form is voluntary. However, failure to provide all or part of the requested information required may affect our ability to evaluate if the denial for extra help with Medicare prescription drug plan costs was correct.

We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. 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 Medicare 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 the 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 of Social Security programs.

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 System of Records Notice entitled, Medicare Database (MDB) File, 60-0321. This notice, additional information regarding

this form, and information regarding our programs and systems, are available on-line at http://www.socialsecurity.gov or at your local Social Security office.

FORM APPROVED
OMB No. 0960-0707

ACKNOWLEDGEMENT FORM

(*RETURN THIS SHEET IMMEDIATELY*)

Beneficiary's Name	Beneficiary's SSN
_____	_____

1. **Will you be available at the time requested?** ☐ **Yes** ☐ **No**

2. What telephone number can we use to reach you, including area code? ( )_____

3. If you will not be available at the time requested, we can reschedule your appointment. If you would like to reschedule, please let us know when you will be available at that number.

   _____

4. **Is your address shown correctly on this letter?** ☐ **Yes** ☐ **No**
   If "NO", please show the appropriate address below:

   _____

   _____

5. **If you need assistance with the telephone interview due to a hearing impairment, please check/complete the appropriate box(es) shown below:**

   ☐ I am deaf or hard of hearing. I will have a person to assist me with this telephone interview. His/her name is _____. He/she is my _____ (indicate your relationship).

   ☐ I am deaf or hard of hearing. SSA may call me with the assistance of a Telephone State Relay System operator.

6. **If you need assistance with the telephone interview due to language problems, please check and complete the appropriate box(es) shown below:**

   ☐ I need a language interpreter. I speak_____(indicate language).

   ☐ I will provide a qualified language interpreter for this telephone interview. His/her name is _____. He/she is my _____ (indicate your relationship).
   (Your interpreter should be 18 years of age or older).

   ☐ I want SSA to provide a qualified language interpreter for this phone interview at no cost to me.

Sign here ▶	_____ (SIGNATURE of Beneficiary or Payee if applicable)	_____ Date

QRA_____

Notice of Appointment-Denial-Please Call Reviewer
SSA-9312 (4-2007)