


Appeal Request (561)

ap001 Welcome

SocialSecurityOnline **Disability Appeal**
www.socialsecurity.gov



Welcome. Thank you for filing your disability appeal online.

Before you begin...
You need to have your [Notice of Decision](#).

We recommend you review the following links:

- [Video: Preparing to File Your Disability Appeal Online](#)
- [Checklist: Information You Will Need](#)
- [Tips for Using this Website](#)
- [Instructions for Blind or Visually Impaired Users](#)

You may also want to review:

- [Social Security's Definition of Disability](#)
- [How the Disability Appeal Process Works](#)
- [Information About Social Security's Disability Programs](#)
- [Your Right to Representation](#)
- [Other Ways to Complete a Disability Appeal](#)

To start your disability appeal...
Please read [Tips for Using this Website](#).

[Start Your Appeal](#)

To continue working on your disability appeal...
If you want to finish a disability appeal you already started:


[Go Back to the Appeal You Already Started](#)

[Contact Us](#) | [Tips for Using this Website](#)

ap004 Can you use this online disability appeal

SocialSecurityOnline
www.socialsecurity.gov

Disability Appeal

 **Can you use this online disability appeal?**

Please note: If you are helping another person fill out this appeal, answer all of the questions as they apply to the person you are helping.

To complete an appeal online, you must have a [notice of decision](#).

* Do you live in the United States or one of its territories / commonwealths? Yes No

* Did you receive a notice of decision? Yes No

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ap005 Claimant information

SocialSecurityOnline **Disability Appeal**
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 **Claimant information**

Please note: "Claimant" refers to the adult or child whose disability decision is being appealed.

* **Claimant Name:** Suffix (if any)

(Enter the first, middle and last name of the person applying for benefits.)

* **Claimant Social Security Number:**

Please enter the Social Security Number without dashes or hyphens.

* **Claimant date of birth:**

* **What is the date on the "Notice of Decision" you received?**


(If you do not know which date we are referring to, see [What is My Notice Date?](#))

* **Claimant residence ZIP code:**

(Enter the ZIP code for the address where the claimant lives. This helps us to process the appeal properly.)

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ap008rc Request for reconsideration


SocialSecurityOnline www.socialsecurity.gov		Disability Appeal	
Name: John Public SSN: xxx-xx-0533		 Request for reconsideration	
		OMB NO. 0960-0622 Paperwork Reduction Act	
Your privacy is important. For details about our use of your information, we encourage you to read our Privacy Act Statement .			
Name of Claimant:		John G Public	
(First, Middle, Last)			
* Claimant Mailing Address:			
Please provide a complete address, including apartment number if applicable. Please do NOT use punctuation; for example, no periods or commas. Example: 528 Dawn St Apt 101. If the address on your notice is correct, please enter it exactly as it appears on the denial notice.			
* (Street Line 1)		<input type="text"/>	
(Street Line 2)		<input type="text"/>	
(Street Line 3)		<input type="text"/>	
(Street Line 4)		<input type="text"/>	
* (City, State, ZIP Code)		<input type="text"/> <input type="text"/> <input type="text"/>	
Claimant Telephone Number:		<input type="text"/>	
Example: (111) 222-3333			
Wage Earner Name (If different from Claimant):		<input type="text"/> <input type="text"/> Suffix (if any) <input type="text"/>	
(First, Middle, Last) Who is the Wage Earner?			
Claimant Social Security Number (SSN):		xxx-xx-0533	
Claimant Claim Number: (If different from SSN):		<input type="text"/>	
What is the Claim Number?			
Supplemental Security Income (SSI) Claim Number:		<input type="text"/>	
What is the Claim Number?			
I do not agree with the determination made on the above claim and request reconsideration.			
Enter a brief explanation of the reason for your appeal. 205 character maximum. This is about 4 lines of typing.		* My reasons are:	
<input type="text"/>		<input type="text"/>	
<input type="button" value="Count Characters"/> You have entered			
0 characters			
* Do you currently have a representative?		<input type="radio"/> Yes <input type="radio"/> No	
* Select one:		<input type="radio"/> I am completing this form as the Claimant.	
		<input type="radio"/> I am completing this form as the Claimant's Representative.	
<input type="button" value="Next"/>			
Contact Us Tips for Using this Website			

ap010rc Submit your request for reconsideration (1st party)

Social Security Online
www.socialsecurity.gov


Disability Appeal

Name: **John Public**
SSN: **xxx-xx-0533**



Review and submit your request for reconsideration

Please review and submit your request for reconsideration below. If you need to make changes, select "Previous" to go back. To submit your request select "Submit" and continue to the next portion of your appeal.

 **The answers you provided are shown in bold text. This will be your last chance to change your answers.**

My name is John G Public. My mailing address is 666 Main Street, Baltimore, MD 21087. My phone number is (410) 666-1212.

My Social Security number is xxx-xx-0533.

I disagree with the determination made on my claim and request reconsideration. My reasons are: my condition has gotten worse.

I do not have a representative.

I understand that I have a right to be represented. If I am not represented but would like to be, the Social Security office can give me a list of legal referral and service organizations.

I, John G Public, 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 and correct to the best of my knowledge.

* I, John G Public, have read and agree with the above.

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ap010rc Submit your request for reconsideration (3rd party)

SocialSecurityOnline
www.socialsecurity.gov

Disability Appeal

Name: John Public
SSN: xxx-xx-0533



Review and submit your request for reconsideration

Please review and submit your request for reconsideration below. If you need to make changes, select "Previous" to go back. To submit your request select "Submit" and continue to the next portion of your appeal.



The answers you provided are shown in bold text. This will be your last chance to change your answers.

Claimant's name is **John G Public**. The Claimant's mailing address is **666 Main Street, Baltimore, MD 21097**. The Claimant's phone number is **(410) 666-1212**.

Claimant's Social Security number is **xxx-xx-0533**. Claimant's claim number is **xxx-xx-1234A**.

The Claimant **disagrees with the determination made on his or her claim and requests reconsideration. The reasons are: my condition has gotten worse.**

The Claimant is represented by **Mike P Representative**, who is an attorney. If not done so previously, the Claimant will complete and submit form SSA-1696 (Appointment of Representative). The Representative's mailing address is **111 South Street, Baltimore, MD 21212**.

I, **Mike P Representative**, 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 and correct to the best of my knowledge.

I, Mike P Representative, have read and agree with the above.

Previous

Submit

[Center link](#) [Tip for Using this Website](#)

ap011rc Receipt for reconsideration (1st party)

SocialSecurityOnline

www.socialsecurity.gov

Disability Appeal

Name: **John Public**
SSN: **xxx-xx-0533**



Print your reentry number and receipt

To print or save this page, please use your browser's Print button or File menu commands.

You have completed the initial portion of your disability appeal. You have provided enough information to obtain a receipt and reentry number. Your reentry number allows you to continue the appeal later if you cannot proceed at this time.

During the next, and final, part of the disability appeal process, we will ask you to provide information on your medical condition. This information is necessary to make a medical decision on your appeal. We recommend you complete your appeal now. **Select "Next" to continue.**

Your reentry number is: **15771424**

To continue with this appeal later, go to www.socialsecurity.gov/disability/appeal and select "Go Back to the Appeal You Already Started."

Guard your reentry number carefully because you must have it to reenter the appeal. Do not put it where an unauthorized person can see it.

Social Security employees cannot access your reentry number.

Receipt of Request for Reconsideration

We received your Request for Reconsideration on September 26, 2011 at 1:16:33 pm Eastern Time.

This is your receipt for the request portion of your appeal. Contact Social Security within ten days after September 26, 2011 if any of the information below is not correct.

My name is John G Public. My mailing address is 555 Main Street, Baltimore, MD 21087. My phone number is (410) 555-1212.

My Social Security number is xxx-xx-0533.

I disagree with the determination made on my claim and request reconsideration. My reasons are: my condition has gotten worse.

I do not have a representative.

I understand that I have a right to be represented at the hearing. If I am not represented but would like to be, the Social Security office can give me a list of legal referral and service organizations.

[Sign Off \(finish later\)](#)

[Next](#)

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Disability Appeal

Name: **John Public**
SSN: xxx-xx-0533



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Sign Off (finish later)

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