



Instructions for Completing the Appeal of Determination for Extra Help with Medicare Prescription Drug Plan Costs

WHEN TO USE THIS FORM: Use Form SSA-1021 to appeal Social Security's determination regarding eligibility or continuing eligibility for Extra Help with your Medicare prescription drug plan costs.

1. ***APPLICANT'S NAME:***

Print name as it appears on your Social Security card.

2. ***SOCIAL SECURITY NUMBER:***

Print Social Security number as it appears on your Social Security card.

3. ***MEDICARE NUMBER:***

Complete only if your Medicare number is different from your Social Security number.

4. ***SPOUSE'S NAME:***

Print name as it appears on your spouse's Social Security card. Complete only if your spouse lives at the same address

5. ***SPOUSE'S SOCIAL SECURITY NUMBER:***

Print Social Security number as it appears on your spouse's Social Security card. Complete only if your spouse lives at the same address.

6. ***SPOUSE'S MEDICARE NUMBER:***

Complete only if your spouse lives at the same address and his or her Medicare number is different from his or her Social Security number.

7. ***PLEASE EXPLAIN WHY YOU DISAGREE WITH OUR DECISION:***

Briefly state the determination that you disagree with and why you disagree with that determination. You can add to this statement by attaching additional pages.

8. ***DO YOU HAVE ADDITIONAL INFORMATION TO SUPPORT YOUR APPEAL:***

If there is more information you want us to see, you can mail it with this form to:

**Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1030
Wilkes-Barre, PA 18767-1030**

9. ***DO YOU WANT A HEARING?***

Check YES if you want a hearing by telephone. Check NO if you do not want a hearing by telephone. If you do not want a hearing, we will make a decision based on the information we have available and any additional information you provide. We call this a case review.

10. ***DO YOU WANT A HEARING SOONER IF SCHEDULING PERMITS?***

We must allow at least 20 days from the date we receive your appeal request and the date we schedule the hearing to give you time to prepare. If you want a hearing sooner, check YES. Check NO if you want us to schedule the hearing at least 20 days from the date we receive your appeal request.



11. DO YOU NEED AN INTERPRETER?

**Check YES and specify the language you prefer and we will provide interpreter services.
Check NO if you do not need an interpreter.**

12. ARE YOU HEARING IMPAIRED?

Check YES if you require the use of a telecommunications device for the deaf to communicate. Check NO if you are not hearing impaired.

13. WILL YOU HAVE OTHER PEOPLE AT THE HEARING?

**Check YES if you will have people other than yourself on the telephone conversation.
Check NO if you will not have any other people at the hearing by the telephone. If YES,
will you and the other people need to talk to us from more than one telephone number?
Check YES if you will have people calling in from a telephone number different from
yours. Otherwise, check NO.**

SEND THE FORM:

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**
