

Applicant Name: [APPLICANT'S NAME]

Applicant SSN: 999999999

Phone Number: () -

Spouse Name: [SPOUSE'S NAME]

Spouse SSN: 999999999

Languages: ENGLISH(S)-ENGLISH(W)

Appeal of Determination for Help with Medicare Prescription Drug Plan Costs

Court Remand Indicator	<input type="checkbox"/>
Applicant's Name	[APPLICANT'S NAME]
Applicant's Social Security Number/ID#	999999999
Applicant's Medicare Claim Number	999999999
Spouse's Name	[SPOUSE'S NAME]
Spouse's Social Security Number/ID#	999999999
Spouse's Medicare Claim Number	
Who is Filing an appeal?	<input type="radio"/> Both you and your spouse are appealing your decisions <input checked="" type="radio"/> Only you are appealing your decision <input type="radio"/> Only your spouse is appealing his or her decision <input type="radio"/> Not Yet Answered
Please explain why you disagree with our decision	CLAIMANT EXPLANATION FIELD UP TO 500 CHARACTERS OF TEXT
Do you have additional information to support your appeal?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Not Yet Answered
Do you want a hearing? If you have a hearing, it will be by telephone.	<input type="radio"/> Yes. You will receive a notice with the date and time of the hearing <input checked="" type="radio"/> No. You will receive a decision based on the information available and any additional information provided <input type="radio"/> Not Yet Answered

Continue Quit

Applicant Name: [CLAIMANT'S NAME]

Applicant SSN: 999999999

Phone Number: () -

Spouse Name: [SOUSE'S NAME]

Spouse SSN: 999999999

Languages: ENGLISH(S)-ENGLISH(W)

Appeal of Determination for Help with Medicare Prescription Drug Plan Costs

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 allows?

- Yes
- No
- Not Yet Answered

Do you need an interpreter?

- Yes
- No
- Not Yet Answered

If YES, please select one of the following languages

Not Yet Answered

Are you hearing impaired?

- Yes
- No
- Not Yet Answered

Will you have other people at the hearing?

- Yes
- No
- Not Yet Answered

If YES, will you and the other people need to talk to us from more than one telephone number?

- Yes
- No
- Not Yet Answered

Section A

Home Address

Street Address 100 PARK AVE

Apartment No.

Address Line 3

Address Line 4

City MONOPOLY BD Zip 99999 -

Phone Number (555) 555 . 555

Consular Code Foreign Postal Code

Foreign Country Geographic Code

*Foreign addresses are not sent to CPMS

Address Source Master Beneficiary Record

Section B

If you prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone.

Contact Person's Name First M.I. Last Suffix

Contact Person's Phone Number () -

Section C

- Third Party Application Help**
- Not Applicable
 - Family Member
 - Friend
 - Attorney
 - Agency
 - Advocate
 - Social Worker
 - Other Specify

Third Party Name First M.I. Last Suffix

Third Party Address

Street Address

Apartment No.

Address Line 3

Address Line 4

City State Zip -

Phone Number () -

Date and Time scheduling options

Appeals Unit I13

Preferred Hearing Date # 1 --

Preferred Hearing Date # 2 --

Appeal of Determination for Help with Medicare Prescription Drug Plan Costs

Summary	
Applicant Name	[CLAIMANT'S NAME]
Applicant SSN	999999999
Applicant Medicare Claim Number	999999999
Spouse Name	[SPOUSE'S NAME]
Spouse SSN	999999999
Spouse Medicare Claim Number	
Who is Filing an Appeal	Both you and your spouse are appealing
Claimant's Statement Explaining Good Cause for Late Filing of Appeal	100 CHARACTER PREVIEW OF CLAIMANTS GOOD CAUSE STATEMENT
Why do You Disagree	100 CHARACTER PREVIEW OF CLAIMANT'S EXPLANATION
Additional Information	No
Telephone Hearing	No

Save and Return

Previous