Privacy Act / Paperwork Reduction Notice

Sections 1631(c)(1)(A) and 1860 D-14 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent a timely and accurate decision on your appeal.

We will use the information to determine your eligibility for assistance paying towards a Medicare Prescription Drug Plan. We may also share your information for the following purposes, called routine uses:

1. To applicants, claimants, prospective applicants or claimants (other than the data subjects and their authorized representatives) to the extent necessary for the purpose of pursuing Medicare Part D and Part D subsidy entitlement or appeal rights; and

2. To the Centers of Medicare and Medicaid Services, for the purpose of administering Medicare Part D enrollment and premium collection and Medicare Advantage Part C premium collections, as well as Medicare Part B income-related monthly adjustment amounts.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0321, entitled Medicare Database File. Additional information and a full listing of all our SORNs are available on our website at **www.socialsecurity.gov/foia/blueblook**.

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, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

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 spouse's 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 you provide.

10. 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 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** 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.

☐ **NO**

Please return your completed appeal form, including the signature page, and any additional information to:

Social Security Administration
Wilkes-Barre Direct Operations Center
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 the Social Security Administration 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 someone assisted you, 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 someone assisted you, place an [X] in the box that describes that person and provide the rest of the information requested below.

☐ Family Member ☐ Attorney ☐ Advocate ☐ Other Specify: _____

☐ Friend ☐ Agency ☐ Social Worker _____

Print First Name:	Print Last Name:	Phone Number: (____) ____ – ____

Address:	Apt. #:

City:	State:	ZIP Code: