**Social Security Administration**
**Office of Quality Review**

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**(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, we would like to telephone you 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. If you do provide the information and your subsidy level is correct, we will not have to contact you to review your eligibility for at least a year. However, if the information is incorrect or you do not provide the information, we may contact you to review your eligibility within the next few months. Such a review of your eligibility could result in your subsidy level increasing, decreasing, or stopping.

We would also like to remind you that if you (and your spouse if married and living together) have a change in your income, resources, or household size you should report this information to Social Security.

## WHAT WILL HAPPEN WHEN WE CALL

We will identify ourselves by name as shown at the bottom of this letter. We 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

We have enclosed a page that shows the kinds of information you should have ready. We have checked the things we would like to talk about. If you do not have all of the information that we are requesting, we 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 we call.

## PLEASE RETURN THE ENCLOSED FORM

**We have enclosed an acknowledgment form for you to complete, sign and mail back to us in the envelope we have provided. You do not need to put a stamp on**

**the envelope. This form is to let us know you received the letter and whether or not you will be available when we plan to call you.**

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

Sincerely,

Social Insurance Specialist

Enclosures

# PRIVACY ACT AND PAPER REDUCTION ACT NOTICE

**Privacy Act Statement**
**Collection and Use of Personal Information**

Section 1860D-14A of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may result in changes or termination of your Medicare Part D subsidy.

We will use the information to document your availability for an interview and to make a determination of continued eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To the Centers for Medicare & Medicare 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; and

2. To Federal and State agencies administering Medicare Part D and Part D subsidy under the Medicare Prescription Drug Improvement and Modernization Act of 2003.

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/bluebook.

**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 (OMB) 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 relating to our time estimate above to:** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

FORM APPROVED
OMB No. 0960-0707

# ACKNOWLEDGMENT 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-Reviewer Will Call**
**SSA-9302 (Rev 11-2014)**