

REQUEST FOR PART B MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE

(Amount in controversy must be \$500 or more (\$100 or more for home health services), QIO — \$200 or more, HMO/CMP/Health Plan — \$100 or more) Take or mail original and all copies to your local Social Security office.

**SEE PRIVACY
ACT NOTICE
ON REVERSE
SIDE OF
FORM**

1. Appellant (The party appealing the carrier/intermediary fair hearing or the QIO or HMO/CMP/Health Plan reconsideration determination)

2. Beneficiary (Leave blank if same as the appellant)

3. Provider, Practitioner or Supplier (Leave blank if same as the appellant)

Address

Address

City State Zip Code

City State Zip Code

Area Code/Telephone Number

Health Insurance (Medicare) Claim Number

5. Answer the following questions that apply

A. Does request involve multiple claims? Yes No

B. Does request involve multiple beneficiaries? Yes No

(If yes, a list of beneficiaries, their HICNs, and the dates of the applicable Fair Hearing/reconsideration determinations must be attached.)

C. Was assignment taken? Yes No

D. If assignment was not taken, are you a physician being held liable pursuant to 1842(l)(1)(A) of the Social Security Act? Yes No

Address

City State Zip Code

6. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because

7. You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. (If you are represented, complete Form CMS-1696 or SSA-1696.)

8. Check I wish to appear in person.
Only One Statement I do not wish to appear in person and I request that a decision be made on the basis of the evidence in my case. (Complete Waiver Form HA-4608)

9. Check I have additional evidence to submit.
Only One Statement I have no additional evidence to submit.

10. The appellant should complete No. 11 and the representative, if any, should complete No. 12. If a representative is not present to sign, print his or her name in No. 12. Where applicable, check to indicate if appellant will accompany the representative at the hearing. Yes No

11. Appellant's Signature

12. Representative's Signature/Name

Address

Address

Attorney
 Non-Attorney

City State Zip Code

City State Zip Code

Date Telephone Number ()

Date Telephone Number ()

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

13. Is this request timely filed? Yes No If "No" is checked:
1. Attach appellant's explanation for delay.
2. Attach any pertinent letter, material or information in the Social Security office.

14. Interpreter Needed (Language, including sign language)

15. Appellant not represented List of legal referral and service organizations provided

16. ACKNOWLEDGMENT OF REQUEST FOR HEARING

This request for hearing was filed on _____ at _____.
The Administrative Law Judge will notify you of the time and place of the hearing at least 20 days in advance of the hearing.

17. For the Social Security Administration

By _____
(Signature/Title)

(Street)

(City/State/ZipCode)

Servicing Social Security Office Code _____

18. HEARING OFFICE COPY

TO: OHA Part B Center _____
 OHA Hearing Office _____
(QIO, HMO/CMP/Health Plan or entitlement case only)
 Other _____

19. CLAIM FILE COPY

TO: Intermediary QIO
 Carrier HMO/CMP/Health Plan
 Other _____

PRIVACY ACT STATEMENT

The collection of information on this form is authorized by the Social Security Act (section 205(a) of title II, section 702 of title VII, sections 1631(e)(1)(A) and (B) of title XVI, and sections 1869(b)(1) and (c) of title XVIII, as appropriate). The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Social Security Administration or other agencies.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0567. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.