DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REQUEST FOR PART A MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE

(Amount in controversy must be $100 or more, PRO-$200 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 reconsidered 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:	

4. Insurance Company *(or Peer Review Organization which made determination on your Medicare claim)*	**5.** Period in Question
Address:	From:
City: State: Zip Code:	To:

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 SSA-1696.)*

8. Check Only One Statement:	**9.** Check Only One Statement:
❑ I **wish** to appear in person.	❑ I **have** additional evidence to submit.
❑ 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)*	❑ 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 or 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/Zip Code)
Servicing Social Security Office Code _____

18. HEARING OFFICE COPY
TO:
❑ OHA Hearing Office _____
(location)
❑ Other _____

19. CLAIM FILE COPY
TO: ❑ Intermediary ❑ HMO/CMP
❑ PRO
❑ Other

Form CMS-5011A U6 (06/91)

ATTACH A COPY OF THE RECONSIDERED DETERMINATION (IF AVAILABLE) TO THIS COPY.

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, section 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.