SOCIAL SECURITY ADMINISTRATION/OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Take or mail original and all copies to your local Social Security Office)

See Privacy Act Notice on Reverse

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT
3. SOCIAL SECURITY CLAIM NUMBER	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER *(Complete ONLY in Supplemental Security Income Case)*

5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

ADDITIONAL EVIDENCE

If you have additional evidence submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

IMPORTANT: Write your Social Security Claim Number on any letter or material you send us.

SIGNATURE BLOCKS: You should complete No. 6 and your representative (if any) should complete No. 7. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 7.

DATE	☐ ATTORNEY ☐ NON-ATTORNEY	
6. CLAIMANT'S SIGNATURE	7. REPRESENTATIVE'S SIGNATURE	
PRINT NAME	PRINT NAME	
ADDRESS	ADDRESS	
(CITY, STATE, ZIP CODE)	(CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER (INCLUDE AREA CODE)	TELEPHONE NUMBER	FAX NUMBER(INCLUDE AREA CODE)

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

8. Request received for the Social Security Administration on _____ by: _____

(Title) (Address) Servicing FO Code PC Code

9. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? ☐ Yes ☐ No

10. If no checked: (1) attach claimant's explanation for delay; and
(2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

11. Check one:
☐ Initial Entitlement
☐ Termination or other

APPEALS COUNCIL
OFFICE OF HEARINGS AND APPEALS, SSA
5107 Leesburg Pike
FALLS CHURCH, VA 22041 - 3255

12. Check all claim types that apply:
☐ Retirement or survivors (RSI)
☐ Disability-Worker (DIWC)
☐ Disability-Widow(er) (DIWW)
☐ Disability-Child (DIWC)
☐ SSI Aged (SSIA)
☐ SSI Blind (SSIB)
☐ SSI Disability (SSID)
☐ Health Insurance-Part A (HIA)
☐ Health Insurance-Part B (HIB)
☐ Other - Specify: _____

PAPERWORK/PRIVACY ACT NOTICE

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We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

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The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

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