

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

(Take or mail the **signed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)

See Privacy Act Notice

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.

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 and correct to the best of my knowledge.

6. CLAIMANT'S SIGNATURE	DATE	7. REPRESENTATIVE'S SIGNATURE	<input type="checkbox"/> ATTORNEY <input type="checkbox"/> NON-ATTORNEY
PRINT NAME		PRINT NAME	
ADDRESS		ADDRESS	
(CITY, STATE, ZIP CODE)		(CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER () -	FAX NUMBER () -	TELEPHONE NUMBER () -	FAX NUMBER () -

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

8. Request received for the Social Security Administration on _____ by: _____
(Date) (Print Name)

(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: <input type="checkbox"/> Initial Entitlement <input type="checkbox"/> Termination or other	12. Check all claim types that apply: <input type="checkbox"/> Retirement or survivors (RSI) <input type="checkbox"/> Disability-Worker (DIWE) <input type="checkbox"/> Disability-Widow(er) (DIWW) <input type="checkbox"/> Disability-Child (DIWC) <input type="checkbox"/> SSI Aged (SSIA) <input type="checkbox"/> SSI Blind (SSIB) <input type="checkbox"/> SSI Disability (SSID) <input type="checkbox"/> Health Insurance-Part A (HIA) <input type="checkbox"/> Health Insurance-Part B (HIB) <input type="checkbox"/> Title VIII Only (SVB) <input type="checkbox"/> Title VIII/Title XVI (SVB/SSI) <input type="checkbox"/> Other - Specify: _____
APPEALS COUNCIL OFFICE OF HEARINGS AND APPEALS, SSA 5107 Leesburg Pike FALLS CHURCH, VA 22041 - 3255	