REQUEST FOR REVIEW OF HEARING DECISION/ORDER

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

(Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office, the Department of 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 Name

2. Claimant SSN	3. Claim Number (If different than SSN)

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

☐ Please grant me an extension of time to submit evidence or argument.

ADDITIONAL EVIDENCE

You may submit any additional evidence or argument to the Appeals Council. If you have additional evidence that relates to the period on or before the date of the hearing decision, you must inform the Appeals Council about it or submit it, or any other evidence or argument, when you submit this form unless you request an extension of time by checking the box above. This will ensure that the Appeals Council has the opportunity to consider the additional evidence before taking its action. If you have a representative, then they must help you obtain the evidence. In limited circumstances, the Appeals Council may request the additional evidence related to the relevant period. If you submit neither evidence nor a legal argument now or within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence currently in your file.

IMPORTANT: WRITE YOUR SOCIAL SECURITY NUMBER ON ANY LETTER OR MATERIAL YOU SEND US. IF YOU RECEIVED A BARCODE FROM US, THE BARCODE SHOULD ACCOMPANY THIS DOCUMENT AND ANY OTHER MATERIAL YOU SUBMIT TO US.

SIGNATURE BLOCKS: You should complete No. 5 and your representative (if any) should complete No. 6. If you are represented and your representative is not available to complete this form, you should also print their name, address, etc. in section number 6.

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.

5. Claimant's Signature	Date

Print Name

Mailing Address

City	State	Zip Code

Telephone Number	Fax Number

6. Representative's Signature	Date

Print Name ☐ Attorney ☐ Non-Attorney

Address

City	State	Zip Code

Telephone Number	Fax Number

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

7. Request received for the Social Security Administration on _____ (Date)

by: _____ (Print Name) _____ (Title)

_____ (Address)

_____ (Servicing FO Code) _____ (PC Code)

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

9. 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.

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

Social Security Administration
Appeals Council
6401 Security Blvd
Baltimore, MD 21235-6401

TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS

11. Check all claim types that apply:

☐ Retirement or Survivors	(RSI)	☐ SSI Disability	(SSID)
☐ Disability - Worker	(DIWC)	☐ Title VIII Only	(SVB)
☐ Disability - Widow(er)	(DIWW)	☐ Title VIII/Title XVI	(SVB/SSI)
☐ Disability - Child	(DIWC)	☐ Other - Specify:	
☐ SSI Aged	(SSIA)		
☐ SSI Blind	(SSIB)		

Privacy Act Statement
Request for Review of Hearing Decision/Order

Sections 205(a), 702, 1631(e), and 1869 (b) and (c) of the Social Security Act, as amended, allow us to collect this information, which we will use to complete our claims process. Providing the information is voluntary, but not providing all or part of the information may prevent the continued processing of any claim filed. As law permits, we may use and share the information you submit, including with other Federal agencies, contractors, and others, as outlined in the routine uses within System of Records Notices 60-0005 and 60-0089, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs for Federal benefits eligibility or to recoup debts under these programs.

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 control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments related to our time estimate or other aspects of this collection to this address, not the completed form.***