SOCIAL SECURITY ADMINISTRATION/OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

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

CLAIMANT SSN
- -

2. WAGE EARNER NAME, IF DIFFERENT

3. CLAIMANT CLAIM NUMBER, IF DIFFERENT
- -

4. 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. This will ensure that the Appeals Council has the opportunity to consider the additional evidence before taking its action. 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 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 his or her name, address, etc. in No. 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		6. REPRESENTATIVE'S SIGNATURE DATE	
PRINT NAME		PRINT NAME ☐ ATTORNEY ☐ NON-ATTORNEY	
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

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

(Title) (Address) (Servicing FO Code) (PC Code)

8. Is the request for review received within 65 days of the ALJ'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

11. 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)
- ☐ Title VIII Only (SVB)
- ☐ Title VIII/Title XVI (SVB/SSI)
- ☐ Other - Specify: ____________

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

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