DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

WAIVER OF RIGHT TO AN ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

Name of Party Requesting the Waiver:

Name	Social Security Number

Health Insurance Claim (HIC) Number	ALJ Appeal Number

Phone Number	E-mail
( )	

Although my right to a hearing before an ALJ has been explained to me, I do not want to participate in the hearing. I want to have my case decided on the record without a hearing. The reason I do not want to participate in the hearing is:

I understand it is my right to have a hearing before the Administrative Law Judge (ALJ). I understand that having a hearing would provide me with the opportunity to present written evidence, my testimony, and the testimony of other witnesses. I understand that this opportunity to be seen and heard could be helpful to the ALJ in making a decision.

I understand that if I do not attend the hearing, I still have the right to submit written evidence.

I understand that my waiver of right to an ALJ hearing does not affect the right of other parties to participate the ALJ hearing.

I understand that even if all parties have waived the right to appear, if the ALJ determines that it is necessary to obtain testimony from a non-party, the ALJ may still hold a hearing to obtain that testimony. In that case, the ALJ will offer the parties the opportunity to appear when the testimony is given, but may hold the hearing even if none of the parties decide to appear.

If I change my mind and decide to request a hearing before the ALJ, I understand that I must make this request before the notice of decision by the ALJ has been issued. If I withdraw my waiver of hearing, I understand that the ALJ may extend the timeframe to reach a decision in order to schedule and hold the hearing.

I understand that the ALJ may deny my waiver request if the ALJ determines that my attendance is necessary to decide the case.

Signature of party *(or party's representative)*	Date

PRIVACY ACT STATEMENT

The legal authority for collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(h)(I), and 1876 of Title XVIII). The information provided will be used to further document your appeal. The Social Security Number will be used to verify the identity of the individual appellant. Submission of the 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 appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.