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

WITHDRAWAL OF REQUEST FOR AN ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

Appellant Name	Street Address	
City	State	ZIP Code
Telephone Number ( )	E-Mail	
Appellant's Representative *(if applicable)*	Street Address	
City	State	ZIP Code
Telephone Number ( )	E-Mail	
Beneficiary Name *(leave blank if same as above)*	Health Insurance Claim (HIC) Number	
Provider/Supplier Name *(leave blank if same as above)*	ALJ Appeal Number	

I, _____ , the appellant, wish to withdraw my request for an Administrative Law Judge (ALJ) hearing before the Office of Medicare Hearings and Appeals (OMHA) that I filed on _____ / _____ / 20_____. I do not intend to further proceed with the appeal. I understand that by withdrawing my request for an ALJ hearing, my appeal will be dismissed by the ALJ if no other party to the Center for Medicare and Medicaid Services (CMS) contractor's reconsideration determination or fair hearing decision has filed a valid Request for ALJ Hearing. I understand that the ALJ will not honor my request if the Notice of Decision has already been issued. I wish to withdraw my request for an ALJ hearing because: *(Please use a separate sheet of paper if more room is needed.)*

Appellant (or representative) Signature	Date

If the appellant's representative is completing this form, the representative must read and sign the following statement:
I am legally authorized to represent the appellant. I have fulfilled my duty to advise the appellant of the consequences of the withdrawal of the request for hearing and subsequent dismissal.

Representative's Signature	Date

PRIVACY ACT STATEMENT

The legal authority for the 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. 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.