

REQUEST FOR COPY OF RECORD(S): THIRD-PARTY WITH THE INDIVIDUAL APPELLANT'S CONSENT

This form is only applicable to third-parties with consent from the individual appellant.

I, the Office of Medicare Hearings the appellant to have copies of the second s			, am re h and Human	equesting a cop Services. I hav	y of the following record(s) from e received written consent from	
Please check if applicable: NOTE: If you are not requesting a title of the record and the c	I am requesting a copy of the entire r	a copy of the enti	ecify below in	detail the record	ting a partial copy of the record (s) you are requesting. Include the er sheet of paper.	
Please provide the information	for the appellant i	f available:				
Name				ALJ Appeal Number		
Health Insurance Claim (HIC) Nur	Social Security Number			Date of Birth		
Please check if applicable:	I have already re		f the record(s)	l am requestin	g.	
The requested record(s) will be sent to the following address: Street 0				City		
				,		
State	ZIP Code		Third-Party's	Third-Party's Phone Number		
	APPELLANT CONSENT					
Please attach the individual appellant's of form entitled "Individual Appellant's Con consent must be signed and dated by be if you are only authorized to have access to be redacted, for instance the appellar	sent to Third-Party for oth you and the individu is to a portion, the con	Copies of the Indiv ual appellant and m sent must specify v	idual Appellant's ust specify whetl which record(s).	Record(s)," HHS - ner you have acces The consent must	721 , to satisfy these requirements. The ss to the entire record or only a portion. also specify whether any information is	
		HOW TO CALCUL				
You may be charged a fee for photocop susceptible to photocopying is assessed \$25, the requesting party will be charge listed in this form unless otherwise spe when we have received payment for the	at actual cost. No cha d in full. The Office of cified if we determine	arge will be made if Medicare Hearings	the total amount and Appeals (C	of copying does n OMHA) will send y	ot exceed \$25. If the total cost exceeds ou an invoice to the address you have	
The OMHA will make every effort	to deliver a copy of	the requested re	ecords before	the date of the	hearing.	
		PRIVACY ACT ST	ATEMENT			
The legal authority for the collection of (5), 1860D-4(h)(1), 1869(h)(I), and 18 Number will be used to verify the iden provide all or any part of the requested by the Office of Medicare Hearings an with Federal laws requiring the disclose	76 of Title XVIII). The tity of the individual a information may affe d Appeals to another	te information prov appellant. Submissi ct the determination person or governm	vided will be use ion of the inform n of your appeal ental agency on	ed to further documentation requested of . Information you ly with respect to	ment your appeal. The Social Security in this form is voluntary, but failure to furnish on this form may be disclosed the Medicare Program and to comply	

other agencies.