REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **completed original** to your local Social Security office, the 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
Myrtle Johnson	123-45-6789	

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:
The reviewer did not consider my doctor's statement that I met the listing and my illness is even worse. Also, although a SSA doctor apparently signed my denial there is no evidence in my file showing a doctor did anything but sign what someone else wrote.

An Administrative Law Judge of the Social Security Administration's Office of Hearings Operations or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 75 days before the date of hearing from the Social Security Administration, and 20 days before the date of hearing from the Department of Health and Human Services.

5. I have additional evidence to submit. ☒ Yes ☐ No

Name and source of additional evidence, if not included.
Paul Dogood,M.D.,455 Medical Way, Baltimore, MD 43407

Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks

☒ I wish to appear at a hearing.

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

Representation: You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

7. CLAIMANT SIGNATURE (OPTIONAL)	DATE	8. NAME OF REPRESENTATIVE (if any)	DATE
	6/24/24		

RESIDENCE ADDRESS			ADDRESS		
2300 Illard Way					
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
Baltimore	MD	43202			
TELEPHONE NUMBER	FAX NUMBER		TELEPHONE NUMBER	FAX NUMBER	
1-(555)-555-5555					

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING

9. Request received on _____ (Date) by: _____ (Print Name) _____ (Title)

_____ (Address) (Servicing FO Code) (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No
If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? ☐ Yes ☐ No

12. Interpreter needed ☐ Yes ☐ No
Language (including sign language):

13. Check one: ☐ Initial Entitlement Case
☐ Disability Cessation Case or ☐ Other Postentitlement Case

14. HO COPY SENT TO: _____ HO on _____
☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI;
☐ T VIII; ☐ T XVIII; ☐ T II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T XVIII
(Copy of email or phone report attached)

16. CF COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title (T) II; ☐ T XVI; ☐ T XVIII
☐ Other Attached: _____

15. Check all claim types that apply:

☐ Retirement and Survivors Insurance Only	(RSI)
☐ Title II Disability - Worker or child only	(DIWC)
☐ Title II Disability - Widow(er) only	(DIWW)
☐ Title XVI (SSI) Aged only	(SSIA)
☐ Title XVI Blind only	(SSIB)
☐ Title XVI Disability only	(SSID)
☐ Title XVI/Title II Concurrent Aged Claim	(SSAC)
☐ Title XVI/Title II Concurrent Blind	(SSBC)
☐ Title XVI/Title II Concurrent Disability	(SSDC)
☐ Title XVIII Hospital/Supplementary Insurance	(HI/SMI)
☐ Title VIII Only Special Veterans Benefits	(SVB)
☐ Title VIII/Title XVI	(SVB/SSI)
☐ Other - Specify:	