



Instructions for Completing the Appeal of Determination for Extra Help with Medicare Prescription Drug Plan Costs

WHEN TO USE THIS FORM: Use Form SSA-1021 to appeal SSA's determinations regarding eligibility or continuing eligibility for a Medicare Part D subsidy.

1. APPLICANT'S NAME:

Name of the individual who is requesting the appeal.

2. SOCIAL SECURITY NUMBER:

Social Security number of the individual for whom the appeal is being filed.

3. MEDICARE NUMBER:

Complete only if Medicare number differs from your Social Security number.

4. SPOUSE'S NAME:

Complete only if spouse lives at the same address.

5. SPOUSE'S SOCIAL SECURITY NUMBER:

Complete only if spouse lives at the same address.

6. SPOUSE'S MEDICARE NUMBER:

Complete only if spouse lives at the same address and Medicare number differs from spouse's Social Security number.

7. PLEASE EXPLAIN WHY YOU DISAGREE WITH OUR DECISION:

Briefly state the determination with which you disagree and why you disagree with that determination. You can add to this statement by attaching additional pages.

8. DO YOU HAVE ADDITIONAL INFORMATION TO SUPPORT YOUR APPEAL:

If there is more information you want us to see, you can mail it with this form to:

Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1030
Wilkes-Barre, PA 18767-1030

9. DO YOU WANT A HEARING?

Check YES if you want a hearing by telephone. Check NO if you want a case review which means we will make a decision based on the information we have available and any additional information provided.

10. DO YOU WANT A HEARING SOONER IF SCHEDULING PERMITS?

We must allow at least 20 days from the date we receive your appeal request and the date we schedule the hearing to give you time to prepare. If you want a hearing sooner, check YES. Check NO if you want us to schedule the hearing at least 20 days from the date we receive your appeal request.



11. DO YOU NEED AN INTERPRETER?

Check YES and specify the language you prefer and we will provide interpreter services. Check NO if you do not need an interpreter.

12. ARE YOU HEARING IMPAIRED?

Check YES if you require the use of a telecommunications device for the deaf to communicate. Check NO if you are not hearing impaired.

13. WILL YOU HAVE OTHER PEOPLE AT THE HEARING?

Check YES if you will have individuals other than yourself on the telephone conversation. Check YES again if you will have individuals calling in from a telephone number different from yours. Otherwise, check NO.

SEND THE FORM:

Please return your completed appeal form, including the signature page, and any additional information to:

**Social Security Administration
Wilkes-Barre Data Operations Center
P.O. Box 1030
Wilkes-Barre, PA 18767-1030**
