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

PETITION TO OBTAIN APPROVAL OF A FEE FOR REPRESENTING A BENEFICIARY

Instructions: An attorney or other appointed representative for a beneficiary must request and obtain approval to charge a fee for services rendered in connection with an appeal before the Office of Medicare Hearings and Appeals (OMHA), **unless** a fee arrangement was made for purposes of making a claim for third party payment. A fee arrangement made to represent a beneficiary in a claim for third party payment does not require approval, even if the representation ultimately includes a Medicare Secondary Payer recovery claim. A representative must submit a fee petition to the assigned Administrative Law Judge (ALJ) no later than 60 days after the date the notice of decision, dismissal, remand, or escalation was mailed, and must provide a copy to the beneficiary.

Section 1: What is your (the representative's) information? (*Beneficiary information in next section*)

Name	Firm or Organization (*if applicable*)	Telephone Number	
Mailing Address	City	State	ZIP Code

Section 2: What is the beneficiary's information?

Name	Health Insurance Claim Number (HICN)	Telephone Number	
Mailing Address	City	State	ZIP Code

Section 3: Representative and fee information: To be completed by the representative.

1. Are you an attorney? ☐ No ☐ Yes
2. Have you ever been disbarred or suspended from a court or bar to which you were previously admitted? ☐ Not applicable (I am not an attorney) ☐ No ☐ Yes
3. Have you been disqualified from participating in or appearing before a Federal program? ☐ No ☐ Yes
4. Have you and your client entered into a fee agreement for services provided in connection with an appeal before OMHA (if yes, please attach a copy)? ☐ No ☐ Yes
5. Itemized list of services: **On a separate page or pages**, itemize the services you rendered in connection with an appeal before OMHA. List each meeting, conference, item of correspondence, telephone call and other activity in which you engaged (such as research, preparation of a brief, attendance at a hearing, or travel) related to your services as a representative in this case. Please provide the date, description, and actual amount of time spent on each service, and the total number of hours. For services not yet rendered, include the expected number of hours and hourly rate, plus any retainer. For a contingency fee, please describe the terms.
6. Complete the following statement: I request approval to charge a total fee (actual and anticipated) of $__________________ for services rendered before OMHA as the appointed representative of the Medicare beneficiary identified above, in connection with the following OMHA Appeal Number(s):

By signing this document, I verify that all statements made in this fee petition and any accompanying documents are true and accurate, to the best of my knowledge.

Representative Signature	Date

Section 4: OPTIONAL beneficiary agreement: You (the representative) may ask the beneficiary to sign this petition and indicate agreement with the fee amount. The beneficiary should mark **one** of the following choices and sign below.

☐ I agree with the $ ______________________ fee, which my representative is asking to charge and collect. By signing this request, I am not giving up my right to later disagree with the total amount approved by the ALJ.

☐ I do not agree with the requested fee or other information given here, or I need more time.

As the beneficiary, I understand that I do not have to sign this petition, and that it is my right to disagree with the amount of the fee requested or any information given.

Beneficiary 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(b)(1), 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.

If you need large print or assistance, please call 1-855-556-8475