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

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, _____ , am requesting a copy of the following record(s) from the Office of Medicare Hearings and Appeals, Department of Health and Human Services. I have received written consent from the appellant to have copies of the appellant's record(s).

Please check if applicable: ☐ I am requesting a copy of the entire record ☐ I am requesting a partial copy of the record

NOTE: If you are not requesting a copy of the entire record, please specify below in detail the record(s) you are requesting. Include the title of the record and the date it was sent/created. If you need more room please attach another sheet of paper.

Please provide the information for the appellant if available:

Name		ALJ Appeal Number
Health Insurance Claim (HIC) Number	Social Security Number	Date of Birth

Please check if applicable: ☐ I have already received a copy of the record(s) I am requesting.

The requested record(s) will be sent to the following address:

Street		City
State	ZIP Code	Third-Party's Phone Number

APPELLANT CONSENT

Please attach the individual appellant's original written consent that authorizes you to have copies of the individual appellant's record(s). You should use the form entitled "Individual Appellant's Consent to Third-Party for Copies of the Individual Appellant's Record(s)," **HHS-721**, to satisfy these requirements. The consent must be signed and dated by both you and the individual appellant and must specify whether you have access to the entire record or only a portion. If you are only authorized to have access to a portion, the consent must specify which record(s). The consent must also specify whether any information is to be redacted, for instance the appellant's Social Security or Medicare number. You must get the written consent notarized by an official notary public.

HOW TO CALCULATE FEES

You may be charged a fee for photocopying. Copying of records susceptible to photocopying is assessed at 10 cents per page and copying of records not susceptible to photocopying is assessed at actual cost. No charge will be made if the total amount of copying does not exceed $25. If the total cost exceeds $25, the requesting party will be charged in full. The Office of Medicare Hearings and Appeals (OMHA) will send you an invoice to the address you have listed in this form unless otherwise specified if we determine that you will be charged a fee for photocopying. The OMHA will send the requested copies when we have received payment for the fee.

The OMHA will make every effort to deliver a copy of the requested records before the date of the hearing.

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. The Social Security Number will be used to verify the identity of the individual appellant. 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.