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

IDENTITY VERIFICATION

INSTRUCTIONS

If the Office of Medicare Hearings and Appeals (OMHA) has asked you to verify your identity, for instance, in order to receive notification of whether the OMHA has any records in which you are identified, please complete this form.

Name	Date of Birth	Social Security Number

Street Address

City	State	ZIP Code

Phone Number	E-Mail Address
( )	

VERIFYING YOUR IDENTITY

In order to verify your identity, you must have the statement below notarized by an official notary public.

I _____, certify that I am in fact the individual I claim to be. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense under the Privacy Act subject to a $5,000 fine.

Individual's Name		**NOTARY SEAL**
Individual's Signature	Date	
Notary Public's Name		
Notary Public's Signature	Date	**Notary's Expiration 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(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.