

REQUEST FOR RECONSIDERATION

(Do not write in this space)

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

NAME OF CLAIMANT	NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON <i>(If different from claimant.)</i>
SOCIAL SECURITY CLAIM NUMBER	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER
SPOUSE'S NAME <i>(Complete ONLY in SSI cases)</i>	SPOUSE'S SOCIAL SECURITY NUMBER <i>(Complete ONLY in SSI cases)</i>

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital insurance, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See reverse of claimant's copy)

"I want to appeal your decision about my claim for supplemental security income (SSI) or special veterans benefits (SVB). I've read the back of this form about the three ways to appeal. I've checked the box below."

Case Review Informal Conference Formal Conference

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE <input type="checkbox"/> NON-ATTORNEY <input type="checkbox"/> ATTORNEY			CLAIMANT SIGNATURE		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER <i>(Include area code)</i>		DATE	TELEPHONE NUMBER <i>(Include area code)</i>		DATE

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See reverse of claim folder copy for list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO	2. CLAIMANT INSISTS ON FILING <input type="checkbox"/> YES <input type="checkbox"/> NO
3. IS THIS REQUEST FILED TIMELY? <i>(If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office.)</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)	SOCIAL SECURITY OFFICE ADDRESS
<input type="checkbox"/> NO FURTHER DEVELOPMENT REQUIRED (GN 03102.125)	
<input type="checkbox"/> REQUIRED DEVELOPMENT ATTACHED	
<input type="checkbox"/> REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS	

ROUTING INSTRUCTIONS (CHECK ONE) →	<input type="checkbox"/> DISABILITY DETERMINATION SERVICES <i>(ROUTE WITH DISABILITY FOLDER)</i>	<input type="checkbox"/> PROGRAM SERVICE CENTER	<input type="checkbox"/> DISTRICT OFFICE RECONSIDERATION
	<input type="checkbox"/> ODO, BALTIMORE	<input type="checkbox"/> OIO, BALTIMORE	<input type="checkbox"/> CENTRAL PROCESSING SITE (SVB)
	<input type="checkbox"/> OEO, BALTIMORE		

NOTE: TAKE OR MAIL COMPLETED COPIES TO YOUR SOCIAL SECURITY OFFICE