SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION

(**Do not** use this form for objecting to a recommended **ALJ** decision.)

(Either mail the signed original form to the Appeals Council at the address shown below, or take or mail the signed original to your local Social Security office, the Department of Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service Post and keep a copy for your records.)

See Privacy Act Notice

1. CLAIMANT NAME	2. CLAIMANT SSN	3. CLAIM NUMBER (if different than SSN)
I		

4. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

☐ Please grant me an extension of time to submit the evidence or argument.

ADDITIONAL EVIDENCE

If you have additional evidence that relates to the period on or before the date of the hearing decision, you must inform the Appeals Council about it or submit it. If you have a representative, then your representative must help you obtain the evidence unless the evidence falls under an exception. You may also submit any other additional evidence to the Appeals Council. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. This will ensure that the Appeals Council has the opportunity to consider the additional evidence before taking its action. If you submit neither evidence nor legal argument now or within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence currently in your file.

IMPORTANT: WRITE YOUR SOCIAL SECURITY NUMBER ON ANY LETTER OR MATERIAL YOU SEND US. IF YOU RECEIVED A BARCODE FROM US, THE BARCODE SHOULD ACCOMPANY THIS DOCUMENT AND ANY OTHER MATERIAL YOU SUBMIT TO US.

SIGNATURE BLOCKS: You should complete No. 5 and your representative (if any) should complete No. 6. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 6.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

5. CLAIMANT'S SIGNATURE	DATE	6. REPRESENTATIVE'S SIGNATURE	DATE
	4/26/2017		4/26/2017

PRINT NAME	PRINT NAME ☒ ATTORNEY ☐ NON ATTORNEY
I	Clifford L. Weisberg, Esq.
ADDRESS, CITY, STATE, ZIP	ADDRESS, CITY, STATE, ZIP
	3000 Town Center, # 1820, Southfield, MI 48075

TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER
		248-281-4247	

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

7. Request received for the Social Security Administration on _____ by: _____
(Date) (Print Name)

(Title) (Address) (Serving FO Code) (PC Code)

8. Is the request for review received within 65 days of the ALJ'S Decision/Dismissal? ☐ YES ☐ NO

9. If "No" checked: ☐ (1) attach claimant's explanation for delay; and
☐ (2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

10. Check one: ☐ Initial Entitlement ☐ Termination or other

APPEALS COUNCIL
OFFICE OF DISABILITY ADJUDICATION
AND REVIEW
5107 Leesburg Pike
FALLS CHURCH, VA 22041 - 3255

11. Check all claim types that apply:
- ☐ Retirement or survivors (RSI)
- ☐ Disability---Worker (DIWC)
- ☐ Disability--Widow(er) (DIWW)
- ☐ Disability--Child (DIWC)
- ☐ SSI Aged (SSIA)
- ☐ SSI Blind (SSIB)
- ☐ SSI Disability (SSID)
- ☐ Health Insurance-Part A (HIA)
- ☐ Health Insurance-Part B (HIB)
- ☐ Other--Specify: