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

REQUEST FOR SUBSTITUTION OF PARTY UPON DEATH OF PARTY

DECEASED PARTY INFORMATION

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

COMPLETE THIS SECTION IF THE DECEASED PARTY WAS THE APPELLANT

I have been informed that the appellant had requested an Administrative Law Judge (ALJ) hearing with the Office of Medicare Hearings and Appeals (OMHA), but died before action on the request was completed. I understand that the deceased appellant's request for hearing will have to be dismissed unless an eligible person is substituted.

Please check one of the following:

☐ I have a genuine financial interest in some or all of the deceased appellant's claims. I have attached evidence of my legal authority to act on behalf of the deceased appellant.

☐ No individual with a genuine financial interest in some or all of the deceased appellant's claims exists. I am the provider or supplier who furnished the item(s) or service(s) involved in the appeal. I have attached evidence of the transaction(s).

Please check one of the following:

☐ I do not wish to proceed with the hearing requested by the deceased, and I withdraw the request for hearing.

☐ I wish to proceed with the hearing. If you do wish to proceed with a hearing, please check one of the following:

- ☐ I want the Administrative Law Judge to hold a hearing
- ☐ I want the decision to be made based on the written evidence in the record without a hearing

COMPLETE THIS SECTION IF THE DECEASED PARTY WAS NOT THE APPELLANT

I have been informed that the deceased was a party to an appeal before an ALJ at the OMHA. I understand that the deceased party will no longer be a party to that appeal unless an eligible person is substituted. I have a genuine financial interest in the deceased party's estate and have attached evidence of my legal authority to act on behalf of the deceased party.

☐ I wish to attend the hearing. ☐ I do not wish to attend the hearing.

SUBSTITUTE PARTY INFORMATION

Substitute Party Name *(printed)*		Social Security Number	
Relationship to Deceased	Date of Birth	Phone Number ( )	
Street	City	State	ZIP Code
Alternate Phone Number ( )	FAX Number ( )	E-Mail	

You have the right to be represented. If you are not represented, but would like to be, contact the Office of Medicare Hearings and Appeals Field Office assigned to your appeal for a list of legal referral and service organizations. If you are represented, and have not already done so, complete form CMS-1696 located at: http://www.hhs.cms.gov/forms .

Substitute Party 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(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.