

**REQUEST FOR RECONSIDERATION**

*(Do not write in this space)*

NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON <i>(If different from claimant.)</i>
CLAIMANT SSN - -	CLAIMANT CLAIM NUMBER <i>(if different from SSN)</i> - -	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 /medical, SSI, SVB, etc.)*

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

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SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY  
*(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision instructions.)*

**"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."**

Case Review     Informal Conference     Formal Conference

**ENTER ADDRESSES FOR THE CLAIMANT AND THE REPRESENTATIVE**

CLAIMANT SIGNATURE- OPTIONAL			NAME OF CLAIMANT'S REPRESENTATIVE <input type="checkbox"/> NON-ATTORNEY <input type="checkbox"/> ATTORNEY		
MAILING ADDRESS			MAILING 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 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 any 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 03102.300)	
<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 the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records.