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

REQUEST FOR COPY OF THE RECORD(S) IN THE CASE FILE

This form is only applicable to appellants and non-appellant beneficiaries.

I, ______________________________ am requesting a copy of the following record(s) from the Office of Medicare Hearings and Appeals, Department of Health and Human Services.

Please check if applicable:

☐ I am requesting a copy of the entire record ☐ I am requesting a partial copy of the record

NOTE: If you are not requesting a copy of the entire record, please specify below in detail the record(s) you are requesting Include the title of the record and the date it was sent/created. If you need more room please attach another sheet of paper.

Type of Requestor *(please check one)*:

☐ Individual Appellant ☐ Entity Appellant ☐ Non-Appellant Beneficiary

☐ Authorized Representative ☐ Appointed Representative ☐ Substitute Party

☐ Other *(if other, please specify your relationship to the appellant)*: ______________________

Please provide the following information for the appellant if available:

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

Please check if applicable: ☐ I have already received a copy of the record(s) I am requesting

The requested record(s) will be sent to the following address:

Street		City
State	ZIP Code	Requestor's Phone Number

PSC Publishing Services (301) 443-6740 EF

INSTRUCTIONS FOR COMPLETING THIS FORM

FEES GENERALLY

Appellants and non-appellant beneficiaries will receive one free copy of the record(s) in the case file. Appellants and non-appellant beneficiaries may be charged for subsequent copies.

If you are a third party, i.e. **not** the individual identified in the record(s) and you have no legal authority to act on behalf of the individual, you will have to obtain the identified individual's consent for access to the record(s). The identified individual is not required to provide such consent. To obtain the identified individual's consent you may use forms HHS-720 and HHS-721 instead of this form (HHS-719).

Representatives of the individual(s) identified in the record(s) who have completed and submitted the "Appointment of Representative" form (CMS-1696), and were subsequently approved by the Administrative Law Judge (ALJ) assigned to the appeal, do not need to obtain a separate consent from the individual identified in the record(s).

Authorized representatives, i.e. individuals who are legally authorized to act on behalf of the individual identified in the record (s), (for instance, a legal guardian or power of attorney), do not need to obtain a separate written consent from the individual so long as they have submitted the legal document that authorized them to act on behalf of the individual. If the legal document, however, does not expressly give the individual's consent to access his or her record(s), submit forms HHS-720 and HHS-721 instead of this form (HHS-719).

Authorized substitute parties who have completed form HHS-722, or some other similar document that verifies your legal status as a substitute party, do not need to obtain a separate written consent from the individual identified in the record(s).

The following requestors must make a Freedom of Information Act (FOIA) request for copies of the record(s):

Third-parties without the written consent of the individual identified in the record(s), whether it is their first or subsequent request for the record(s);

Entity appellants, for instance a provider or supplier organization, making subsequent requests for the record(s); and

Authorized substitute parties subsequent requests for the record(s).

For instructions on how to make a FOIA request, please read the "Instructions for Making a FOIA Request" below.

INSTRUCTIONS FOR MAKING A FOIA REQUEST

If you have been instructed to make a FOIA request, rather than use this form, please read the following. The Department of Health and Human Services FOIA Office requires all FOIA requests to be submitted in writing, by postal service, facsimile, or messenger. Requests must contain the requestor's postal address and the name of the person responsible for paying any fees that may be charged. You should provide a phone number where the FOIA Office can reach you to get clarification of the request or resolve other issues concerning the request. For more information, please go to:

http://www.hhs.gov/about/infoguid.html#foia

FOIA requests should be sent to:

Department FOI Officer
Department of Health and Human Services
200 Independence Ave, S.W.
Room 645F
Washington, D.C. 20201

If the Office of Medicare Hearings and Appeals (OMHA) receives a FOIA request, the OMHA will forward it to the Department FOI Officer.

HOW TO CALCULATE FEES

The fees calculated in this section only apply to those requestors who are eligible to complete this form (HHS-719) as indicated in the instructions and not for FOIA requests.

If the OMHA is charging you a fee for photocopying, the charges will be determined as follows:

Copying of records susceptible to photocopying is assessed at 10 cents per page and copying of records not susceptible to photocopying is assessed at actual cost. No charge will be made if the total amount of copying does not exceed $25. If the total cost exceeds $25, the requesting party will be charged in full.

The OMHA will send you an invoice to the address you have listed on this form, unless otherwise specified, if it is determined that you will be charged a fee for photocopying as described in this form. The OMHA will send the requested copies when payment for the fee has been received.

VERIFYING YOUR IDENTITY

In addition to completing this form, your request must be notarized by an official notary public in order to verify your identity. Please have the following statement notarized:

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.

Requestor's Name		NOTARY SEAL
Requestor's Signature	Date	
Notary Public's Name		
Notary Public's Signature	Date	**Notary's Expiration Date**

The OMHA will make every effort to deliver a copy of the requested records before the date of the hearing.

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.