Appendix 4 - Appointment of Representative - Form CMS-1696-U4

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME (Print or Type)	H.I. CLAIM NUMBER

SECTION I APPOINTMENT OF REPRESENTATIVE

I appoint this individual:_____
(Print or type name and address of individual you want to represent you)

to act as my representative in connection with my claim or asserted right under Titles XI, or XVIII of the Social Security Act. I authorize this individual to make or give any request or notice; to present or to elicit evidence; to obtain information; and to receive any notice in connection with my claim wholly in my stead.

SIGNATURE (Beneficiary)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

SECTION II ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration or the Centers for Medicare & Medicaid Services; that I am not, as a current or former officer or employee of the United States, disqualified from acting as the claimant's representative; and that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations referred to on the reverse side hereof. In the event that I decide not to charge or collect a fee for the representation I will notify the Social Security Administration and the Centers for Medicare & Medicaid Services (completion of Section III (optional) satisfies this requirement).

I am a / an _____
(Attorney, union representative, relative, law student, etc.)

SIGNATURE (Representative)	ADDRESS
TELEPHONE NUMBER (Area Code)	DATE

SECTION III (Optional) WAIVER OF FEE OR DIRECT PAYMENT

(Note to Representative: You may use this portion of the form to waive a fee or to waive direct payment of the fee from withheld past-due benefits.)

I waive my right to charge and collect a fee for representing _____ _____ before the Social Security Administration or the Centers for Medicare & Medicaid Services.

SIGNATURE	DATE

(See important information on reverse)
FORM CMS-1696-U4 (10-84)