NAME: _____

LAST FOUR OF SSN: _____

DATE: _____

TELEPHONE: _____

REQUEST FOR $10 WITHHOLDING OF OVERPAYMENT

Dear SSA Claims Representative:

I currently receive Social Security/SSI benefits. I understand that I have an overpayment on my record. Please limit withholding to $10 per month, as I meet one or more of the following criteria:

_____ I receive a Medicare Low-Income Subsidy (LIS) for Medicare Part D, per the POMS GN 2210.030(B)(6) exception or I receive Medicaid benefits in addition to Medicare which makes me automatically eligible for the Part D LIS.

_____ I receive other cash public assistance, per POMS GN 2210.030(B)(5);

_____ Paying back the overpayment at a rate of more than $10 per month would be a great hardship to me, per POMS GN 02210.045.

Thank you for your attention to this letter and please suspend withholding until you issue me a written decision on my request.

Sincerely yours,

_____

Print Your Name