Name: _____

SSN: _____

Date: _____

Phone Number:_____

Address:_____

Request for $10 Payment Plan of Overpayment

Dear Social Security Claims Representative:

I get Social Security/SSI benefits. You told me that I have an overpayment on my record. I am asking for a payment plan. Please do not take more than $10 per month, because:

_____ I receive Qualified Medicare Beneficiary (QMB) or another Medicare Part D subsidy.[1]

_____ I owe $600 or less and I can't afford to pay more than $10 per month for the overpayment.[2]

_____ I can't afford to pay more than $10 per month for the overpayment.[3] I filled out Form 634 "Request for Change in Overpayment Recovery Rate." I attached that form to this letter.

Thank you for your help.

Sincerely,

_____
Name

[1] *See* POMS GN 02210.030(C).
[2] See POMS GN 02210.030(B).
[3] See POMS GN 02210.030(C).