

DMACOVER}

{@BARCDRIGHT}
{@SERIAL}

SOCIAL SECURITY ADMINISTRATION

**Office of Medical & Vocational
Expertise - OMVE
Post Office Box 32908
Baltimore MD 21241-2908**

DATE: {@DATE}

{@VMADDR}

RE: {@CLMTADDR}

SSN: {CSSN}
{@PATIENTID}
DOB: {CDOB}

{@ALIAS}

{CFNAME} {CLNAME} has filed for disability benefits under the Social Security Act and has asked us to obtain medical evidence to document the claim.

{@alleg}

{@QUESTIONS}

You may prepare a narrative report on your stationery or send copies of the patient's records that include: (1) medical history, (2) physical and/or mental status, (3) therapy and response to treatment, and (4) laboratory or psychological test results. Also forward copies of pertinent hospital summaries or consultant reports that you may have.

TO ENSURE PROMPT SERVICE, PLEASE RETURN THE COVER SHEET AND THIS LETTER WITH YOUR RESPONSE. IF YOU ARE REQUESTING PAYMENT FOR RECORDS, PLEASE SUBMIT YOUR PAYMENT REQUEST NO LATER THAN 90 DAYS FROM WHEN YOU SEND THE RECORDS.

{PFIRSTNAME} {PLASTNAME}

Case Manager

1-{@PALTAREACOD}-{@PALTEXCHG}-{@PALTPHONE4}

Extension: {@PALTEXT}

(toll free)

Enclosures: {@ENCLHV}

Authorization for Release of Medical Records
Business Reply Envelope

OMVE9008/{@OPER}{VMISC10}