Medical Source Information (to be completed by physician)

Signature:_____ Amount:_____

Physician SSN or, if incorporated,
EIN: _____ Date:_____

or

Medical Center Name and
Federal Tax EIN: _____ Date:_____

Remittance Address:_____

Telephone Number:_____

Hearing Office Information (to be completed by hearing office personnel)

Evidence Received by:_____ Date:_____

CAN:_____ SOC:_____ APPROVED FOR PAYMENT BY:_____ DATE:_____

TPD#_____ PAID BY (INITIALS)____ SYSTEMS ID NUMBER_____ DATE:_____

PRIVACY ACT STATEMENT:

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d), 1614(a)(3)(H)(I) and 1631(d)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange information between Social Security and another agency.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a

valid Office of Management and Budget control number. We estimate that it will take you about 15 minutes to read the instructions, gather the necessary facts, and answer the questions.