Sample MER Forms

MER REQUEST FOR HOSPITAL (ADULT)

DDS Letterhead
(includes mailing address)

DATE:

Hospital
Address Line 1
Address Line 2
City, State ZIP

RE: Claimant's Name
Address Line 1
Address Line 2
City, State ZIP

AKA:

Patient ID:
SSN: 000-00-0000
DOB: MM/DD/YY

A claim for Social Security disability benefits has been filed for [CLAIMANT'S NAME] and we have been asked to get medical evidence for the claim.

Please provide [inpatient or outpatient] medical records for [DATE] to [DATE or present].

Medical records should include medical history, clinical and laboratory findings, treatment prescribed and response, diagnosis, prognosis, discharge summary, and a statement based on medical findings, describing the patient's capacity to perform work-related activities.

- Physical work activities include sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking and traveling.

- Mental work activities include understanding and memory; sustained concentration and persistence; social interaction; and adaptation.

Please send either a narrative report or copies of your records and sign your report.

THIS IS NOT AN AUTHORIZATION FOR AN EXAMINATION.

[include State information, if needed]

If you have any questions about our request, please call [PHONE NUMBER].

Thank you for your help.

(OPTIONAL: Name and title of requester)

Enclosures:
Medical Release Form

MER REQUEST FOR CLINIC/PHYSICIAN (ADULT)

DDS Letterhead
(includes mailing address)

DATE:

Clinic/Physician's Name and Title
Address Line 1
Address Line 2
City, State ZIP

RE: Claimant's Name
Address Line 1
Address Line 2
City, State ZIP

AKA:

Patient ID:
SSN: 000-00-0000
DOB: MM/DD/YY

A claim for Social Security disability benefits has been filed for [CLAIMANT'S NAME] and we have been asked to get medical evidence for the claim.

Please provide medical records from [DATE] to [DATE or PRESENT].

Medical records should include medical history, clinical and laboratory findings, treatment prescribed and response, diagnosis, prognosis, and a statement based on medical findings, describing the patient's capacity to perform work-related activities.

- Physical work activities include sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking and traveling.
- Mental work activities include understanding and memory; sustained concentration and persistence; social interaction; and adaptation.

Please send either a narrative report or copies of your records and sign your report.

THIS IS NOT AN AUTHORIZATION FOR AN EXAMINATION.

[include State information, if needed]

If you have any questions about our request, please call [TELEPHONE NUMBER].

Thank you for your help.

(OPTIONAL: Name and title of requester)

Enclosures:
Medical Release Form

MER REQUEST FOR HOSPITAL (CHILD)

DDS Letterhead
(includes mailing address)

DATE:

Hospital
Address Line 1
Address Line 2
City, State ZIP

RE: Claimant's Name
Address Line 1
Address Line 2
City, State ZIP

AKA:

Patient ID:
SSN: 000-00-0000
DOB: MM/DD/YY

A claim for Social Security disability benefits has been filed for [CLAIMANT'S NAME] and we have been asked to get medical evidence for the claim.

Please provide [inpatient or outpatient] medical records for the dates [DATE] to [DATE or present].

Medical records should include medical history, clinical and laboratory findings, treatment prescribed and response, diagnosis, prognosis, discharge summary, and a statement about how the child's impairment(s) and related symptoms affect his or her daily activities and ability to perform age-appropriate activities.

Domains of development or functioning that may be addressed are: cognition; communication; motor abilities; social abilities; responsiveness to stimuli (in children from birth to the attainment of age 1); personal/behavioral patterns (in children from age 1 to the attainment of age 18); and concentration, persistence, and pace in task completion (in children from age 3 to the attainment of age 18).

A narrative report, copies of your records, and completion of any attached forms are equally satisfactory. Please sign your report.

THIS IS NOT AN AUTHORIZATION FOR AN EXAMINATION.

[include State information, if needed]

If you have any questions about our request, please call [TELEPHONE NUMBER].

Thank you for your help.

(OPTIONAL: Name and title of requester)

Enclosures:
Medical Release Form

MER REQUEST FOR CLINIC/PHYSICIAN (CHILD)

DDS Letterhead
(includes mailing address)

DATE:

Clinic/Physician's Name and Title
Address Line 1
Address Line 2
City, State ZIP

RE: Claimant's Name
Address Line 1
Address Line 2
City, State ZIP

AKA:

Patient ID:
SSN: 000-00-0000
DOB: MM/DD/YY

A claim for Social Security disability benefits has been filed for [CLAIMANT'S NAME] and we have been asked to get medical evidence from you for the claim.

Please provide medical records from [DATE] to [DATE or PRESENT].

Medical records should include medical history, clinical findings, treatment prescribed and response, diagnosis, prognosis, and a statement about how the child's impairment(s) and related symptoms affect his or her daily activities and ability to perform age-appropriate activities.

Domains of development or functioning that may be addressed are: cognition; communication; motor abilities; social abilities; responsiveness to stimuli (in children from birth to the attainment of age 1); personal/behavioral patterns (in children from age 1 to the attainment of age 18); and concentration, persistence, and pace in task completion (in children from age 3 to the attainment of age 18).

A narrative report, copies of your records, and completion of any attached forms are equally satisfactory. Please sign your report.

THIS IS NOT AN AUTHORIZATION FOR AN EXAMINATION.

[include State information, if needed]

If you have any questions about our request, please call [TELEPHONE NUMBER].

Thank you for your help.

(OPTIONAL: Name and title of requester)

Enclosures:
Medical Release Form

MER REQUEST FOR SCHOOL/INSTITUTION (CHILD)

DDS Letterhead
(includes mailing address)

DATE:

School/Institution
Address Line 1
Address Line 2
City, State ZIP

RE: Claimant's Name
Address Line 1
Address Line 2
City, State ZIP

AKA:

SSN: 000-00-0000
DOB: MM/DD/YY

A claim for Social Security disability benefits has been filed for [CLAIMANT'S NAME] and we have been asked to get evidence for the claim.

Please send either a narrative report or copies of your records and sign your report.

Records should include attendance/grade reports, reports of any referrals for or results of multi-disciplinary team evaluations, anecdotal records, medical records, and information about how the child's impairment(s) and related symptoms affect his or her school activities and ability to perform age-appropriate activities.

[include State information, if needed]

If you have any questions about our request, please call [PHONE NUMBER].

Thank you for your help.

(OPTIONAL: Name and title of requester)

Enclosures:
Authorization Release Form

MER REQUEST FOR SIGNATURE ON TELEPHONE REPORT (MER)

DDS Letterhead
(includes mailing address)

DATE:

Clinic/Physicians's Name
Address Line 1
Address Line 2
City, State ZIP

RE: Claimant's Name
Address Line 1
Address Line 2
City, State ZIP

AKA:

SSN:
DOB:

Enclosed is a summary of the information you recently gave us on the telephone about this claim for Social Security disability benefits.

Social Security regulations require us to get your signature on this medical report.

Please review, sign, date, and return the enclosed report to us. Please make any revisions necessary. Your prompt response will help assure a timely decision on your patient's claim.

Thank you for your help and cooperation.

(OPTIONAL: Name and title of requestor)

Enclosure:
Medical Report