Form Approved
OMB No. 0960-0677

MEDICAL CONSULTANT'S REVIEW OF PSYCHIATRIC REVIEW TECHNIQUE FORM

SSN: - -

NAME:

NH's NAME *(If DWB, CDB, or DC Claim)*:

PRTF COMPLETED BY *(Identify DDS or RO)*:

DATE OF PRTF BEING REVIEWED:

TYPE OF CLAIM: ☐ Initial ☐ CDR

LEVEL OF CLAIM: ☐ Initial ☐ Recon ☐ DHU

This form is to be completed by the reviewing medical consultant (MC) **ONLY** when a signed **PRTF** is in file and it is determined that a **PRTF** was appropriate.

Part I below serves to record agreement/disagreement with Sections I, III, and IV of the **PRTF**.

Part II serves for the reviewing MC to explain in **DETAILED NARRATIVE FORMAT** the evidentiary bases for recording a disagreement in Part I.

Indicate agreement, disagreement, or not applicable by checkmark for **EACH** item below.
IMPORTANT - Indicate disagreement **ONLY** for **SUBSTANTIVE** issues.

I. SUMMARY OF AGREEMENT/DISAGREEMENT

	AGREE	DISAGREE	NA
A. Categories of Disorders (Section IIA-I of PRTF)	☐	☐	☐
B. Rating of Functional Limitations (Section IIIA 1-4 of PRTF)			
1. Daily Activities	☐	☐	☐
2. Social Functioning	☐	☐	☐
3. Concentration, Persistence, or Pace	☐	☐	☐
4. Decompensation	☐	☐	☐
C. Listing 12.02C, 12.03C, or 12.04C in Remission (Section IIIB1 of PRTF)	☐	☐	☐
D. Listing 12.06C (Section IIIB2 of PRTF)	☐	☐	☐
E. Medical Disposition (Section IB 1-8 of PRTF)	☐	☐	☐

MEDICAL CONSULTANT'S SIGNATURE: _____ MC CODE: _____ DATE: _____

II. NARRATIVE DISCUSSION

Complete this section **ONLY** for discusion of areas of **SUBSTANTIVE DISAGREEMENT**. Present a complete and detailed **NARRATIVE** discussion of the basis for disagreement for **EACH** area.

Begin the **NARRATIVE DISCUSSION** with a statement of why the **PRTF** assessment is in question. Include a statement of the specific evidence that supports your conclusions, which differ substantively from those presented in the **PRTF** assessment. If the disagreement is due to missing or incomplete evidence, identify the evidence that is needed.

☐ Continued On Attached Page

CENTRAL OFFICE REVIEW

Central Office (CO) Reviewing Medical Consultant (MC) ☐ AGREES ☐ DISAGREES with the assessment on this form.

In <u>disagreements</u>, the reviewing CO MC is to complete and attach Form SSA-416, discussing the disagreement issues(s).

MC CODE _____

CO MC Signataure _____ Date _____

See Revised Privacy Act Statement

Privacy Act Statement: Section 223 and section 1633 of the Social Security Act authorize the information requested on this form. The information provided will be used in making a decision on this claim. Completion of this form is mandatory in disability claims involving mental impairments. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or government agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and another agency.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

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.

See Revised Paperwork Reduction Act Statement

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 12 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

The following revised Privacy Act Statement Statement will be inserted into the form at its next scheduled reprinting:

PRIVACY ACT NOTICE

Collection and Use of Personal Information

Sections 223 and 1633 of the Social Security Act, as amended, authorize us to collect the information requested on this form. The information you provide will be used to make a decision on this disability claim. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining entitlement to Social Security benefits. We may, however, disclose the information provided on this form in accordance with approved routine uses of the Privacy Act (5 U.S.C. § 552a(b)), which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;

3. To comply with Federal laws requiring the disclosure of the information from our records; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 12 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to*: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***