SOCIAL SECURITY ADMINISTRATION

FORM APPROVED
OMB NO. 0960-0722

Refer To:

DOB:

Office of Disability Adjudication and Review
Street Address City, State Zip Code
Tel: Fax:

Date

A claim for disability benefits, filed by the above-named individual under the Social Security Act, is before the Office of Hearings and Appeals for hearing and decision.

Please provide the following information within the next ten days:

Your assistance in furnishing this information will facilitate the adjudication of this claim and will be greatly appreciated. A medical release form is enclosed. We are authorized to pay up to $, which is the same amount that the Disability Determination Service Office pays for such a report. If you require payment for the evidence, please supply us with the necessary information requested on the attached page and return this letter with the evidence to our office as soon as possible. If you have any questions, please contact at the phone number listed above.

Thank you for your cooperation.

Sincerely,

Enclosures

cc:

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 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 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213.** *Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.*

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:_____

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