****BARCODE****

AGENCY
LETTERHEAD

Date: _____
Claim ID: _____

Addressee Name
Address Line 1
Address Line 2
City, State, ZIP Code

Claimant: [Fill-in]
DOB: xx/xx/xxxx

We are the office that makes the disability determinations for the Social Security Administration. **[First Name] [Last name]** is applying for or is receiving disability benefits due to the following conditions: ***[List Conditions]***

Please provide medical reports including the following information: medical history, clinical findings, laboratory findings, treatment prescribed and the response, diagnosis, and prognosis.

Please send the information requested below, covering the period of **[*Fill-in date*] to [*Fill-in date*]**, to help us evaluate this claim.

- **[*Fill-in*]** (e.g. history, diagnosis/prognosis, most recent mental status exam, etc.)
- **[*Fill-in*]**

We are enclosing a signed, HIPAA compliant authorization (SSA-827) for release of medical records and information.

[*Optional canned text for claims involving mental impairments*]
Please provide a statement based on your findings. Your statement should express your opinion about your patient's ability to do work-related mental activities *despite the limitations imposed by his/her mental condition(s).* These activities include: understanding, carrying out and remembering instructions, and responding appropriately to supervision, coworkers, and work pressures.

[*Optional canned text for claims involving physical impairments*]
Please provide a statement based on your findings. Your statement should express your opinion about your patient's ability to do work-related physical activities *despite the limitations imposed by his/her medical condition(s).* These activities include sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling.

[*Optional canned text for a claim for a child*]
Please provide a statement based on your findings. Your statement should express your opinion about your patient's abilities and limitations compared with children of the same age without medical conditions. Consider areas such as, but not limited to, age-appropriate learning, attention, interaction with other people, motor functioning, and behavior and self-care. Please also comment on how this child's medical condition(s) and associated treatments, including the frequency of treatment, affect his or her overall functioning.

Submitting Records: Refer to the instructions on the bar-coded cover page.

Payment Information: We will pay you for your report and records. See the attached invoice for instructions. To receive payment, you must complete the attached invoice and submit it with the requested records and statements within **[Fill-in#]** days of the date of this letter.

[*Optional canned text*]
We do not pay any State or Federal facility. If you are in such a facility, you will not find a voucher in this request.

For billing questions or inquiries please call x-xxx-xxx-xxxx.

Other Information: Please indicate if you would be willing to conduct an examination, test, or both at our expense if we later determine that we need more medical information. If you do not respond, we will assume that you do not wish to conduct such an examination of this patient.

_____ Yes, I am interested. _____ No, I am not interested.

If you have any other questions please contact **[*Mr./Ms.*]** **[*Disability Examiner's name*]** at xxx-xxx-xxxx.

If you have no records for this patient please check here _____

CLAIMANT: WOODROW BLANK
DDS CASE NUMBER: 248
DEA: ATE000

DIABETES QUESTIONNAIRE FOR TREATING SOURCE

1. Please include treatment notes, and lab tests from _____ to _____
2. Diagnosis _____

3. Date of onset of symptoms. _____
4. Height _____ Weight _____ Date _____

5. Date and results of the latest blood sugar evaluation and glycohemoglobin (HbA1C).
   _____

6. If acidosis has occurred on the average of at least once every two months, please indicate blood chemical test (PH or PCO2 or bicarbonate levels) and the dates performed. _____
   _____

7. If the patient has sustained an amputation due to diabetic necrosis or peripheral vascular disease, please describe and indicate the date of the amputation.
   _____
   _____

8. If present, please describe any visual abnormalities due to diabetes. _____
   _____

9. Is there any evidence of neuropathy? If so, please describe. Is an assistive device medically required for ambulation? When was it prescribed? _____
   _____

10. Is the Diabetes under satisfactory control? ☐ Yes ☐ No

11. Please describe compliance and response to treatment. _____
    _____
    _____

12. Please indicate any other observable conditions or pertinent clinical findings that might affect the patient's functional abilities. _____

13. Date first seen:_____ Date last seen:_____ Frequency of visits:_____

Thank you for your cooperation.

Physicians Signature _____ Print or type name _____
Date _____
Phone Number_____ Best time to call _____

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Treating Physician
General Medical Evaluation

Directions: Please provide a current assessment using objective findings. This information is necessary to evaluate this patient's disability claim. ***Please indicate if normal. If abnormal, please list specific findings.*** (Please use reverse side if additional space is needed.)

Date of Exam:_____ **Frequency of Visits:**_____

General Appearance

1. Height:_____ Weight:_____ Blood Pressure:_____

Eyes

2. Best Corrected: OD _____ OS _____
3. If uncorrected give: OD _____ OS _____
4. Describe any severe disease/visual defect (including visual fields):_____

Ears

5. Can your patient hear normal conversation? Yes ☐ No ☐
   If no, please explain._____

Respiratory System

6. Lungs:_____
7. Details of dyspnea, if any:_____

Cardiovascular

8. Chest pain of cardiac origin? Yes ☐ No ☐
   If yes, please describe, including symptoms:_____
9. Peripheral vascular pulses:

Abdominal

10. Abdomen/pelvis findings: _____

11. Organomegaly? Yes ☐ No ☐
    If yes, please describe. _____

Musculoskeletal

12. Please provide range of motion (ROM) and describe affected joint(s) and/or spine.

Neurological System

13. Please describe the following:

    a. Gait: _____
    b. Reflexes: _____
    c. Sensory: _____
    d. Motor: _____
    e. Atrophy? Yes ☐ No ☐
       If yes, please describe. _____

    f. Does your patient have seizures? Yes ☐ No ☐
       If yes, please describe (including frequency). _____

Comments:

14. Please provide comments below on other conditions your patient has which are not already described above.

Name of Physician (printed) **Physician Signature**

Date _____ **Telephone # and extension: (_____)** _____

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TREATING SOURCE SUMMARY OF VISION FINDINGS

1. DIAGNOSIS: OD_____

   OS_____

2. DISTANCE VISUAL ACUITY:

   Without correction (leave blank if not checked): OD_____ OS_____ Date_____

   With correction (leave blank if not tested) OD_____ OS_____ Date_____

   Most recent **manifest refraction:** Date _____ Check here if unknown ☐

   OD _____ = 20/_____

   OS _____ = 20/_____

3. Describe any pathological findings:_____

4. What surgery has been performed? None ☐

   OD _____ Date_____

   OS _____ Date_____

5. Has formal **Visual Field** testing been done? Check all that apply.

   ☐ No. ☐ No significant visual field deficit expected.

   ☐ Yes. Was this a reliable field consistent with ocular pathology? ☐ Yes ☐ No

   Date of test _____

   Please include the visual field printouts with this report.

6. Indicate earliest date:
   Best corrected VA in the better eye was limited to 20/200 or worse:
   N/A ____ Date: _____
   Residual visual field in the better eye was 20 degrees or less in widest diameter:
   N/A ____ Date: _____
   Please include supporting clinic notes or VF test results for that date.

7. Please comment on **treatment plan** and **prognosis** over the next 12 months:

_____

_____

_____

Signature of: Physician ☐☐ Optometrist ☐ Date

_____ ( ) _____

MD/OD Name (please print) Phone No. Best time to contact you

SSA will insert the following revised PRA Statement 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 (OMB) control number. The OMB control number for this collection is 0960-0555. We estimate that it will take between 5 to 30 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

PRIVACY ACT STATEMENT
Collection and Use of Information by the Social Security Administration

The Privacy Act of 1974 (5 U.S.C. § 552a) requires us to provide certain facts to each person from whom we request and collect information in order to administer our programs. These facts include:

- the statutory authority for the request;
- why we need the information;
- whether it is voluntary or mandatory for you to give us the information and the effects, if any, of not giving us the information; and
- the uses we may make of the information you give us.

The following sections explain our collection, use, and disclosure of the information you give us. If you have any questions about your rights and responsibilities under the Privacy Act, you may contact any local Social Security office.

Our authority to collect information

Our specific authority to collect information is found in sections 205(a), 702, 1631(e)(1)(A) and (B), 1631(f), 1872, and 1875 of the Social Security Act (the Act), as amended. Additional authority is in part B of the Federal Coal Mine Health and Safety Act of 1969.

Why we need the information

We collect information from you in order to administer our programs. Specifically, the information we request enables us to:

- assign Social Security numbers;
- establish and maintain earnings records;
- determine entitlement of applicants and their families to insurance coverage and or benefit payments;
- issue payments in the right amount for the right months to people entitled to them; and
- conduct program-oriented research in areas of income distribution and maintenance.

Is providing information voluntary or mandatory?

It is not mandatory for you to give us the information we request ***except*** in certain instances explained below. It is usually to your advantage to comply with our request for information. Failure to do so, however, could prevent an accurate and timely decision on a claim you file or result in the loss of some benefit or service.

Our use(s) of the information you give us

We use the information you give us to administer our programs. Sometimes we must disclose the information to another agency or person without your written consent. We make these disclosures for the following reasons:

- to enable a third party or agency to assist us in establishing your right to benefits or coverage;
- to comply with Federal laws;
- to make eligibility determinations in similar Federal, State, and local health and income maintenance programs;
- to facilitate statistical research, audit, or investigative activities necessary to assure the integrity of our programs.

We may also use the information you give us when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use the information from these matching programs 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.

A complete list of routine uses of the information you give us is available in our Privacy Act Systems of Records Notices. For example, the application for benefits and supporting documentation of the factors of entitlement and continuing eligibility is contained in our Claims Folder System (60-0089); medical information, doctors' reports, and State disability determinations related to a disability claim is contained in our National Disability Determination Services File System (60-0044). Additional information regarding this form, routine uses of information, and other Social Security programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.