Model CE Notice

AGENCY
LETTERHEAD

Date: ______________
Case ID: ***[Fill-in]***

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

MEDICAL APPOINTMENT NOTICE(S)

Dear **[First Name] [Last name]**,

We are the office that makes disability determinations for the Social Security Administration. We have made medical appointment(s) for you because we need more information about your condition(s) for your Social Security disability claim. We will pay for this appointment(s).

Your Medical Appointment(s) Information

Name and Address	Phone Number	Date and Time	Type of Appointment(s)*

*The medical evaluator(s) may decide not to do some of the tests we have ordered or that other tests are needed.

Please arrive at your appointment(s) 15 minutes early. If you are late, the medical evaluator(s) may not see you.

What you should do to confirm that you will attend your appointment(s):
[1]Please complete the enclosed response form(s) and mail it in the pre-addressed envelope provided. You should respond to our office within ten days of the date on this letter.

What you should do if you cannot attend your appointment(s) as scheduled:
Please call our office **immediately** if you cannot attend your appointment(s) for any reason. If you cannot attend your scheduled appointment(s), and you would like us to reschedule, you must give us a good reason.

[1] Include this statement only if you enclose Model Response Form 1.

What you should bring to the appointment:
Bring this notice and personal identification (e.g., U.S. State-issued driver's license, U.S. State-issued non-driver identity card, U.S. passport, U.S. military ID, student or school ID). Bring any medications that you take in their original containers. Also, bring your hearing aid(s), eyeglasses, contact lenses, cane(s), or other medical aids if you use them.

What you should do if you have questions or need assistance for the appointment(s):
Contact us if you need assistance paying for travel to the appointment(s) or any unusual expense you must incur getting to the appointment(s). We will only consider payment of these costs if you ask us promptly. We may pay your travel expenses before your appointment(s), but you must show us that your request is **reasonable and necessary**. Also, call us if you need to request special arrangements for this medical evaluation because you have a health issue that makes traveling difficult.

Let us know if you need a foreign language interpreter, a sign language interpreter, or other assistance to communicate effectively with the medical evaluator(s). We will arrange for interpreter services at no cost to you.

What you should do if you want a copy of the report(s) sent to your doctor:
If you want a copy of the report(s) from this medical evaluation sent to your doctor, please provide his or her full name and address. [2]Please complete the enclosed authorization form(s).

What if you miss the scheduled appointment(s):
IF YOU DO NOT ATTEND YOUR APPOINTMENT(S), WE MAY MAKE A DETERMINATION BASED ON THE EVIDENCE WE ALREADY HAVE FOR YOUR CLAIM. WE COULD FIND THAT YOU ARE NOT DISABLED. IF YOU ARE ALREADY GETTING BENEFITS, WE COULD FIND THAT YOU ARE NO LONGER DISABLED. PLEASE READ THE ENCLOSED LEAFLET WHICH EXPLAINS MORE ABOUT THE CONSULTATIVE EVALUATION APPOINTMENT(S) AND YOUR RESPONSIBILITY FOR ATTENDING.

If you have any questions regarding this information or need to contact us about the appointment(s), call Monday-Friday between 8:00 a.m. and 4:00 p.m. at the number below.

Thank you for your cooperation,

(NAME)
(TITLE)
PHONE NUMBER [Fill-in]
TTY/TRS [Fill-in]

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[2] Include this statement only if you enclose Model Response Form 2.

Enclosures:
SSA Publication No. 05-10087 (A Special Examination Is Needed for Your Disability Claim)
[3]Consultative Examination Appointment Confirmation
[4]Authorization to Release a Duplicate of Your Consultative Examination Report

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[3] List this enclosure only if you enclose Model Response Form 1
[4] List this enclosure only if you enclose Model Response Form 2

Model Response Form 1 (Consultative Examination Appointment Confirmation)

AGENCY
LETTERHEAD

Date: ______________
Case ID: ***[Fill-in]***

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

Dear **[First Name] [Last name]**,

Please check the correct box to let us know if you will attend your appointment(s) on ***[Fill-in mm/dd/yyyy]***.

[ ] I will attend the medical appointment(s) scheduled for my Social Security claim:

[ ] I cannot attend the medical appointment(s) because

____.

Appointment Information
Medical Evaluator ***[Fill-in]***
Address ***[Fill-in]***
Date ***[Fill-in]***
Time ***[Fill-in]***

IMPORTANT: Please sign, date, and mail this form as soon as possible using the pre-addressed envelope provided. If you cannot attend the scheduled appointment(s) or will require additional assistance to attend, notify us immediately at (XXX)XXX-XXXX.

______________________________ ______________
(Your Signature) (Date)

Model Response Form 2 (Authorization to Release a Duplicate of Your Consultative Examination Report)

Case ID: ***[Fill-in]***

I,**[First Name] [Last name]**, authorize the Social Security Administration to send a duplicate of the consultative examination report(s) by **[Fill-in names of medical evaluators]** to:

Your Doctor's Name: ______________________
Address Line 1: ______________________
Address Line 2: ______________________
City, State, ZIP code: ______________________

I understand this authorization is valid for 90 days from the date signed or until the date used, whichever occurs first. However, I can revoke this authorization sooner if I submit a written request to do so.

______________________	______________________
(Your Signature)	(Date)
______________________	______________________
(Your Address)	(Your Telephone Number)