SOCIAL SECURITY ADMINISTRATION

Office of Quality Assurance and
Performance Assessment

(Address of Office)
Date:
Beneficiary Name:
SSN:

(Address)

On **(fill-in)**, I spoke with you regarding the review of **(fill-in)**. In order to proceed with the review, the following is needed:

(fill-in)

Please send the requested documents in the enclosed self-addressed, postage-paid envelope. We will return your documents immediately.

If you have questions about this request, contact me at 1-800-**(fill-in)** between 8:00 a.m. and 4:00 p.m., Monday through Friday.

Thank you for your cooperation.

Sincerely,

Social Insurance Specialist

Enclosure(s)

FORM APPROVED
OMB No. 0960-0707

PAPER REDUCTION ACT NOTICE

Paperwork Reduction Act Statement – This information collection meets the requirements of 44 U.S.C section 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. The OMB number for this collection is 0960-0707. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. *Send **only** comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001.*