Sample CE Forms

Letter to Vendor Rescheduling Consultative Examination/Test for Adult

DDS LETTERHEAD
(Includes mailing address)

DATE:

Doctor's Name
Address Line 1
Address Line 2
City, State Zip

RE: Claimant's Name
Address Line 1
Address Line 2
City, State Zip

AKA:

SSN: 000-00-0000
DOB: MM/DD/YY

We had scheduled an appointment for a current examination/test on (claimant) with your office for (date & time), but the examination/test was not performed. This letter is to confirm that we have rescheduled this appointment for (date & time). Your report will help us determine this claimant's eligibility for Social Security or Supplemental Security Income disability benefits.

After the examination, please prepare a narrative report including history (obtained during your interview), all objective findings, diagnosis, and prognosis. We would also like to have a statement about the individual's ability, despite functional limitations imposed by the impairment(s), to perform work-related activities.

- Physical work activities include sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling.
- Mental work activities include understanding and memory; sustained concentration and persistence; social interaction; and adaptation.

Please do not express an opinion about whether the claimant is disabled or capable of working. This judgment frequently depends on nonmedical factors such as age, education, and vocational skills.

If additional tests are needed for your evaluation, you must telephone us at the number above for authorization before such tests are made. The claimant should not be billed for any services provided as a part of this examination.

It is imperative that your medical report be in our office within 10 days after the examination date, as we are under a rigid time limit to complete cases without unnecessary delay.

(include State information, if needed)

Letter to Vendor Regarding Consultative Examination/Test for Child

DDS LETTERHEAD
(Includes mailing address)

DATE:

Doctor's Name
Address Line 1
Address Line 2
City, State Zip

RE: Claimant's Name
Address Line 1
Address Line 2
City, State Zip

AKA:

SSN: 000-00-0000
DOB: MM/DD/YY

We had scheduled an appointment for a current examination/test on (claimant) with your office for (date & time), but the examination/test was not performed. This letter is to confirm that we have rescheduled this appointment for (date & time). Your report will help us determine this claimant's eligibility for Social Security or Supplemental Security Income disability benefits.

After the examination, please prepare a narrative report including medical history (secured during your interview), all objective findings, diagnosis, and prognosis. We would also like to have a statement about how the child's impairment(s) and related symptoms affect his or her daily activities and ability to perform age-appropriate activities.

Domains of development or functioning that may be addressed are: cognition; communication; motor abilities; social abilities; responsiveness to stimuli (in children from birth to age 1); personal/behavioral patterns (in children from age 1 to age 18); and concentration, persistence, and pace in task completion (in children from age 3 to age 18).

If additional tests are needed for your evaluation, you must telephone us at the number above for authorization before such tests are made. The child's parent/guardian or other person responsible for this child should not be billed for any services provided as a part of this examination.

It is imperative that your medical report be in our office within 10 days after the examination date, as we are under a rigid time limit to complete cases without unnecessary delay.

(include State information, if needed)

Cover Letter to Vendor Regarding Consultative Examination/Test Appointment for Adult

DDS LETTERHEAD
(Includes mailing address)

DATE:

Doctor's Name
Address Line 1
Address Line 2
City, State Zip

RE: Claimant's Name
Address Line 1
Address Line 2
City, State Zip

AKA:

SSN: 000-00-0000
DOB: MM/DD/YY

We need a current examination/test of (claimant's name), as shown on the enclosed authorization. We have scheduled the appointment with your office for (date & time). Your report will help us determine this claimant's eligibility for Social Security or Supplemental Security Income disability benefits.

After the examination, please prepare a narrative report including history (obtained during your interview), all objective findings, diagnosis, and prognosis. We would also like to have a statement about the individual's ability, despite functional limitations imposed by the impairment(s), to perform work-related activities.

- Physical work activities include sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling.
- Mental work activities include understanding and memory; sustained concentration and persistence; social interaction; and adaptation.

Please do not express an opinion about whether the claimant is disabled or capable of working. This judgment frequently depends on nonmedical factors such as age, education and vocational skills.

If additional tests are needed for your evaluation, you must telephone us at the number above for authorization before such tests are made. The claimant should not be billed for any services provided as a part of this examination.

It is imperative that your medical report be in our office within 10 days after the examination date, as we are under a rigid time limit to complete cases without unnecessary delay.

(include State information, if needed)

Cover Letter to Vendor Regarding Consultative Examination/Test Appointment for Child

DDS LETTERHEAD
(Includes mailing address)

DATE:

Doctor's Name
Address Line 1
Address Line 2
City, State Zip

RE: Claimant's Name
Address Line 1
Address Line 2
City, State Zip

SSN: 000-00-0000
DOB: MM/DD/YY

We need a current examination/test of the person named in the enclosed authorization. We have scheduled the appointment with your office for (date & time). Your report will help us determine this claimant's eligibility for Supplemental Security Income disability benefits.

After the examination, please prepare a narrative report including medical history (secured during your interview), all objective findings, diagnosis, and prognosis. We would also like to have a statement about how the child's impairment(s) and related symptoms affect his or her daily activities and ability to perform age-appropriate activities.

Domains of development or functioning that may be addressed are: cognition; communication; motor abilities; social abilities; responsiveness to stimuli (in children from birth to age 1); personal/behavioral patterns (in children from age 1 to age 18); and concentration, persistence, and pace in task completion (in children from age 3 to age 18).

If additional tests are needed for your evaluation, you must telephone us at the number above for authorization before such tests are made. The child's parent/guardian or other person responsible for this child should not be billed for any services provided as a part of this examination.

It is imperative that your medical report be in our office within 10 days after the examination date, as we are under a rigid time limit to complete cases without unnecessary delay.

(include State information, if needed)

CE

Enclosure for CE Appointment Letter - Authorization for Release of Consultative Examination/Test Report to Physician of Choice

AUTHORIZATION FOR RELEASE OF
CONSULTATIVE EXAMINATION/TEST REPORT
TO PHYSICIAN OF CHOICE

Claimant's Name: _____

Claimant's SSN: _____

I hereby authorize the release of a copy of the medical report of my consultative examination or test conducted by:

Examining Doctor(s) _____

_____

to: _____
(Name of Treating Physician)

_____
(Address of Treating Physician)

I understand this authorization is valid for up to 90 days, unless revoked in writing by me.

_____ _____
(Claimant Signature) (Date)

_____
(Claimant Address)

Optional Consultative Examination/Test Confirmation Response Form

DDS LETTERHEAD
(Includes mailing address)

Claimant's/Applicant's Name:
Address Line 1
Address Line 2
City, State Zip

DATE:

SSN:

EXAMINER:

Please check the proper box to let us know whether you plan to keep the examination or test appointment scheduled for you on (date & time).

☐ I will keep the appointment.

☐ I cannot keep the appointment because_____

_____

Sign and mail this form in the enclosed envelope as soon as possible.

_____
Your Signature

_____
Date

Bureau of Disability Determination Services

Audrey McCrimon
Director

Illinois Department of Rehabilitation Services

Dear Doctor

We have been informed that you may be interested in performing consultative examinations for our Bureau.

To be included on our Panel of Consultants, we must receive and review your curriculum vitae which should include the following:

1. Medical School and date of graduation.
2. Place and dates of residency training.
3. Social Security Number.
4. State Medical License Number or
   Copy of State Medical License Certificate
5. Whether Board Certified and include speciality.
6. Hospital affiliations.
7. Department name and address of any State of Illinois personnel payroll(s) you are on at this time. *
8. Individual Tax Identification Number (Please complete attached Tax Identification Number Form.)
9. Corporate or group Tax Identification Number if you use one for a group practice.
10. Place and date of birth
11. ECFMG # if foreign medical graduate

Enclosed with this letter is information regarding the disclosure of medical information under the Federal Privacy Act of 1974. Our Bureau is currently required to obtain a written acknowledgement of the responsibility of confidentiality from all persons who perform consultative examinations. You will also find the License/Credentials Certification statement for your signature.

* The Illinois Purchasing Act prohibits State employees from receiving money for goods or services in a contract satisfied by payment of funds appropriated by the Illinois General Assembly. University employees are excepted.

MR:1 - 06-07-94

P.O. Box 19250, Springfield, Illinois 62794-9250 ■ 217/782-7160 (voice) ■ 217/524-2985 (TDD) ■ 217/785-7714 (FAX)

The current fee schedule has been enclosed for your information and future use.

Please forward to us your curriculum vitae and your signed Medical Disclosure Acknowledgement form. Your application will then be given every consideration by the Credentials Committee.

Very truly yours,

Edward G. Ference, M.D.
Chief Medical Consultant

EGF:DR:rt

Enclosures: Federal Privacy Act Informational Sheet
Medical Disclosure Acknowledgement/
License/Credentials Certification
Tax Identification Number Form
Fee Schedule
Envelope

Bureau of Disability Determination Services

Audrey McCrimon
Director

Illinois Department of Rehabilitation Services

Dear

We have been informed that several of your physicians in your group might be interested in performing consultative examinations for our Bureau.

To be included on our Panel of Consultants, we must receive and review each prospective panelist's curriculum vitae. These curricula vitae should include the following:

1. Medical School and date of graduation.
2. Place and dates of residency training.
3. Social Security Number.
4. State Medical License Number.
5. Whether Board Certified and include speciality.
6. Hospital affiliations.
7. Department name and address of any State of Illinois personnel payroll(s) you are on at this time. *
8. Individual Tax Identification Number (Please complete attached Tax Identification Number Form.)
9. Corporate or group Tax Identification Number if one is used for a group practice.
10. Place and date of birth
11. ECFMG # if foreign medical graduate

Enclosed with this letter is information regarding the disclosure of medical information under the Federal Privacy Act of 1974. Our Bureau is currently required to obtain a written acknowledgement of the responsibility for confidentiality from all persons who perform consultative examinations. Therefore, please request each of the doctors to read all of the information carefully and for each to sign one of the Medical Disclosure Acknowledgement forms and the License/ Credentials Certification statement enclosed.

*The Illinois Purchasing Act prohibits State employees from receiving money for goods or services in a contract satisfied by payment of funds appropriated by the Illinois General Assembly. University employees are excepted.

MR:2 - 06-07-94

P.O. Box 19250, Springfield, Illinois 62794-9250 ■ 217/782-7160 (voice) ■ 217/524-2985 (TDD) ■ 217/785-7714 (FAX)

Please forward to us the curricula vitae and the signed Medical Disclosure Acknowledgement forms. These applications will then be given every consideration by the Credentials Committee.

Very truly yours,

Edward G. Ference, M.D.
Chief Medical Consultant

EGF:DR:rt

Enclosures: Federal Privacy Act Information Sheet
Medical Disclosure Acknowledgement/
License/Credentials Certification
Tax Identification Number Form
Fee Schedule
Envelope

Bureau of Disability Determination Services

Audrey McCrimon
Director

Illinois Department of Rehabilitation Services

Dear Doctor

We have been informed that you may be interested in performing consultative examinations for our Bureau.

To be included on our Panel of Consultants, we must receive and review your curriculum vitae which should include the following:

1. School and date of graduation.
2. Social Security Number.
3. Registration Number.
4. Hospital affiliations.
5. Department name and address of any State of Illinois personnel payroll(s) you are on at this time. *
6. Individual Tax Identification Number (Please complete attached Tax Identification Number Form.)
7. Corporate or Group Tax Identification Number if you use one for a group practice.

Enclosed with this letter is information regarding the disclosure of medical information under the Federal Privacy Act of 1974. Our Bureau is currently required to obtain a written acknowledgement of the responsibility of confidentiality from all persons who perform consultative examinations. You will also find the License/ Credentials Certification statement for your signature.

A copy of the current fee schedule has been enclosed for your information and future use.

*The Illinois Purchasing Act prohibits State employees from receiving money for goods or services in a contract satisfied by payment of funds appropriated by the Illinois General Assembly. University employees are excepted.

MR:3 - 06-07-94

P.O. Box 19250, Springfield, Illinois 62794-9250 ■ 217/782-7160 (voice) ■ 217/524-2985 (TDD) ■ 217/785-7714 (FAX)

5

Please forward to us your curriculum vitae and your signed Medical Disclosure Acknowledgement form. Your application will then be given every consideration by the Credentials Committee.

Very truly yours,

Edward G. Ference, M.D.
Chief Medical Consultant

EGF:DR:rt

Enclosures: Federal Privacy Act Information Sheet
Medical Disclosure Acknowledgement
License/Credentials Certification
Tax Identification Number Form
Fee Schedule
Envelope

Bureau of Disability Determination Services

Audrey McCrimon
Director

Illinois Department of Rehabilitation Services

Dear Doctor

We have been informed that several of your psychologists might be interested in performing consultative examinations for our Bureau.

To be included on our Panel of Consultants, we must receive and review each prospective panelist's curriculum vitae. These curricula vitae should include the following:

1. School and date of graduation.
2. Place and date of graduate training and any specialty training.
3. Social Security Number.
4. Registration Number.
5. Hospital affiliations.
6. Department name and address of any State of Illinois personnel payroll(s) you are on at this time. *
7. Individual Tax Identification Number (Please complete attached Tax Identification Number Form.)
8. Corporate or group Tax Identification Number if one is used for a group practice.

Enclosed with this letter is information regarding the Disclosure of Medical Information under the Federal Privacy Act of 1974. Our Bureau is currently required to obtain a written acknowledgement of the responsibility of confidentiality from all persons who perform consultative examinations. Therefore, please request each of your psychologists to read the information carefully and for each to sign one of the Medical Disclosure Acknowledgement forms and the License/ Credentials Certification statement enclosed.

*The Illinois Purchasing Act prohibits State employees from receiving money for goods or services in a contract satisfied by payment of funds appropriated by the Illinois General Assembly. University employees are excepted.

MR:4 - 06-07-94

P.O. Box 19250, Springfield, Illinois 62794-9250 ■ 217/782-7160 (voice) ■ 217/524-2985 (TDD) ■ 217/785-7714 (FAX)

A copy of the current fee schedule has been enclosed for informational purposes and future use.

Please forward to us the curricula vitae and the signed Medical Disclosure Acknowledgement forms. These applications will then be given every consideration by the Credentials Committee.

Sincerely,

Edward G. Ference, M.D.
Chief Medical Consultant

EGF:DR:rt

Enclosures: Federal Privacy Act Informational Sheet
Medical Disclosure Acknowledgement/
License/Credentials Certification
Tax Identification Number Form
Fee Schedule
Envelope