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.

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[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)

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.