SOCIAL SECURITY ADMINISTRATION

Refer To:
[Claimant's SSN]
[ClaimantFirstName][ClaimantLastName]
[ClaimantDOB]

Office of Disability Adjudication and Review
Hearing Office Name
Hearing Office Address
Tel: (xxx)xxx-xxxx / Fax: (xxx)xxx-xxxx

[Today's Date]

[Hospital Name]
[Hospital Address]

A claim for disability benefits, filed by the above-named individual under the Social Security Act, is before the Office of Disability Adjudication and Review for hearing and decision.

Please provide the following information within the next ten days:
[Requested Information]

If you are currently registered as a user of the Electronic Records Express (ERE), use the attached barcode information when submitting the requested evidence (RQID, RF, and DR fields). If you are not a registered user of ERE, fax the evidence, along with the enclosed barcode, using this fax number– [ScanFaxNumber]. Remember that the enclosed barcode must be the first page of each set of documents being faxed. Note: **If you request payment, the request should be returned to the address shown above or sent via the fax number noted below – it is different than the FECS fax number used for medical evidence.**

Your assistance in furnishing this information will facilitate the adjudication of this claim and will be greatly appreciated. A medical release form is enclosed. <ifAuthorizedPayment> We are authorized to pay up to $[FeeAmount], which is the same amount that the Disability Determination Service Office pays for such a report. If you require payment for the evidence, please supply us with the necessary information requested on the attached page and return this letter by mail or fax [OfficeFaxNumber] to our office as soon as possible. <ifFeeSchedule> Please refer to the attached schedule for payment information.<endif> <elseifNoAuthorizedFee> We are not required to pay for medical evidence in this state. <endif>If you have any questions, please contact <ifSignee> [ContactFirstName] [ContactLastName] <elseif>[SigneeName] <endif> at the phone number listed above.

Thank you for your cooperation.

Sincerely,

See Next Page

[SigneeName]
[SigneeTitle]

Enclosures

<if Rep>
cc: <if OBO> [OBOName] on behalf of
[ClaimantFirstName][ClaimantLastName]
[OBOAddress]
<else>
[ClaimantFirstName][ClaimantLastName]
[ClaimantAddress]
<endif>
<endif>

See Next Page

[Hospital Name]
[Hospital Address]

Medical Source Information (to be completed by physician)

Signature: _____ Amount: _____

Physician SSN or, if incorporated, EIN: _____ Date: _____

or

Medical Center Name and Federal Tax EIN: _____ Date: _____

Payee Name – Please Print: (First, Middle Initial, Last Name); Payee SSN, or if incorporated, EIN: (The EIN or SSN must belong to the payee.) _____ Date: _____

Remittance Address: _____

Telephone Number: _____

Hearing Office Information (to be completed by hearing office personnel)

Evidence Received by: _____ Date: _____

CAN: _____ SOC: _____ APPROVED FOR PAYMENT BY: _____ DATE: _____

TPD# _____ PAID BY (INITIALS) _____ SYSTEMS ID NUMBER _____ DATE: _____

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act as amended, [42 U.S.C. 405(a), 1383(d)(1) and 1383(e)(1)] authorize us to collect this information. We will use the information you provide to help us determine the amount of this claim. The information you provide on this form is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on any claim filed.

See Revised Privacy Act Statement Attached

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records to other agencies (e.g., to the Government Accountability Office, and the Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level.

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching agencies can be used 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 for this information is available in our System of Records Notices entitled, Administrative Law Judge Working File on Claimant Cases, 60-0005 and Claims Folders Systems, 60-0089. The notices, additional information regarding this form, and information regarding our system and programs, are available on-line at www.socialsecurity.gov or at any local Social Security office.

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of <u>each set of documents</u> returned.

Fax the evidence to this fax number:

[Scanner Phone number]

RQID:00000000000000000000555514 SITE:T24 DR:S
SSN:006502602 DOCTYPE:0001 RF:D CS:41ff

Sample Barcode above

Claimant: [Claimant Name]
SSN: [Claimant SSN]

SSA will insert the following revised Privacy Act Statement into the form as soon as possible:

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d)(5), 1614(a)(3), and 1631(d)(1) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from remitting payment for the requested information.

We will use the information in the named claimant's disability determination and to remit payment. We may also share your information for the following purposes, called routine uses:

1. To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs; and

2. To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for SSA as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned Agency functions.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0005, entitled Administrative Law Judge Working File on Claimant Cases and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.