Samples

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 2

Date: {Date}
Case ID: {Case ID}

Barcode

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

AUTHORIZATION TO RELEASE CONSULTATIVE EXAMINATION REPORT

Appointment Information

Evaluator Information	**Date and Time**	**Type of Appointment**
{CE Provider Name} {CE Provider Address}	{Weekday} {Appointment Date} {Appointment Time}	{CE Procedure}

I, {Claimant Full Name}, authorize the Social Security Administration to send a copy of the consultative examination report(s) for the appointment(s) listed above to:

Doctor Name: _____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP code: _____

Phone: _____ Fax: _____

I understand this authorization is valid for 90 days from the date signed. I can revoke this authorization sooner if I submit a written request to do so.

_____ _____ _____
Your Signature Date Current Phone Number

_____ _____ _____ _____
Current Address City State Zip

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d) and 1631(d) and (e) 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 making an accurate and timely decision on any claim filed.

We will use the information to make a determination regarding your ability to perform work-related activities. We may also share your information for the following purposes, called routine uses:

1. To private medical and vocational consultants for use in making preparation for, or evaluating the results of, consultative medical examination or vocational assessments which they were engaged to perform by SSA or a State agency acting in accord with sections 221 or 1633 of the Act; and

2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs. We will disclose information under this routine use only in situations in which SSA may enter into a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

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) 60-0044, entitled National Disability Determination Services File System 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.

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. We estimate that it will take about 20 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*.