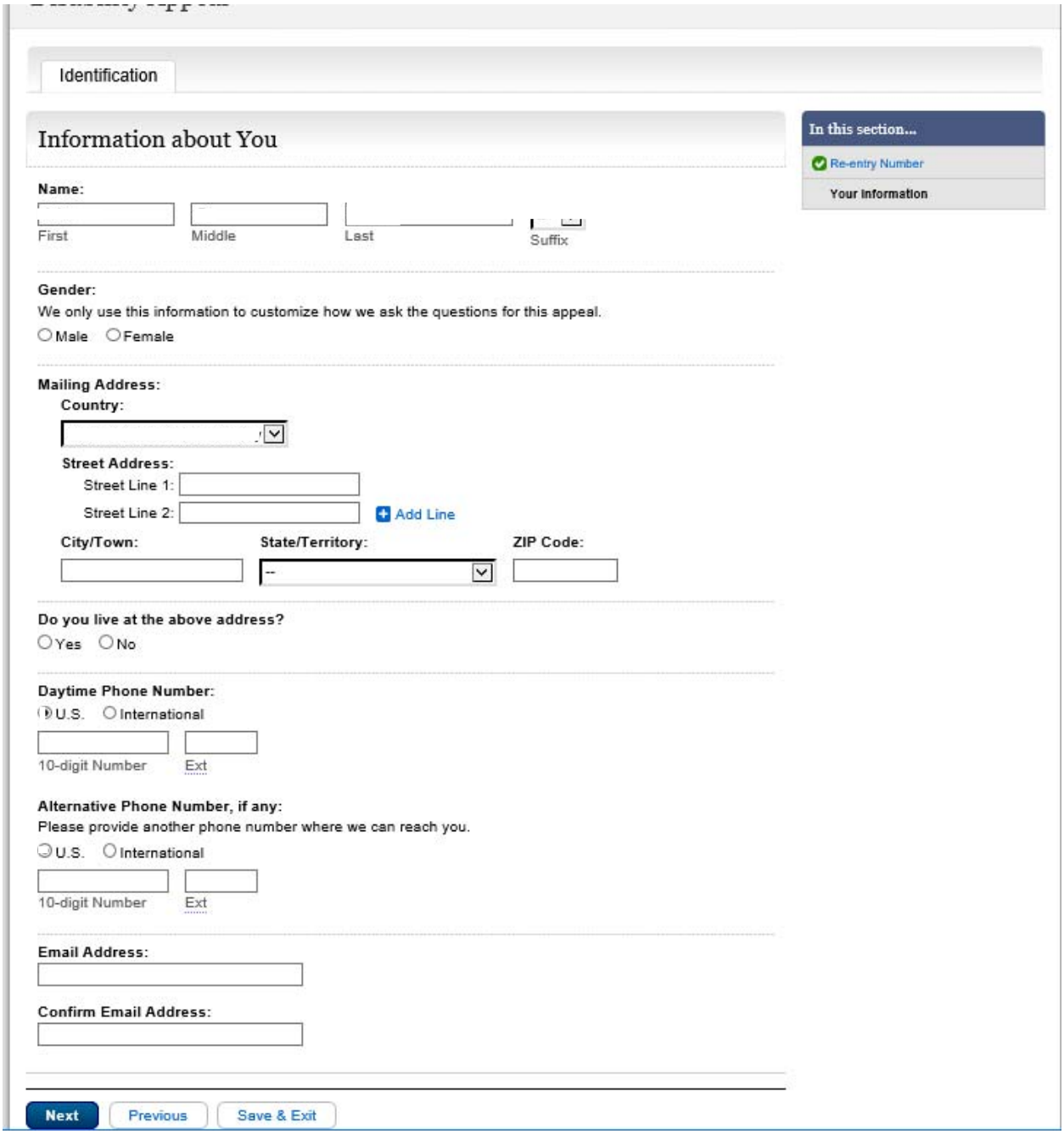
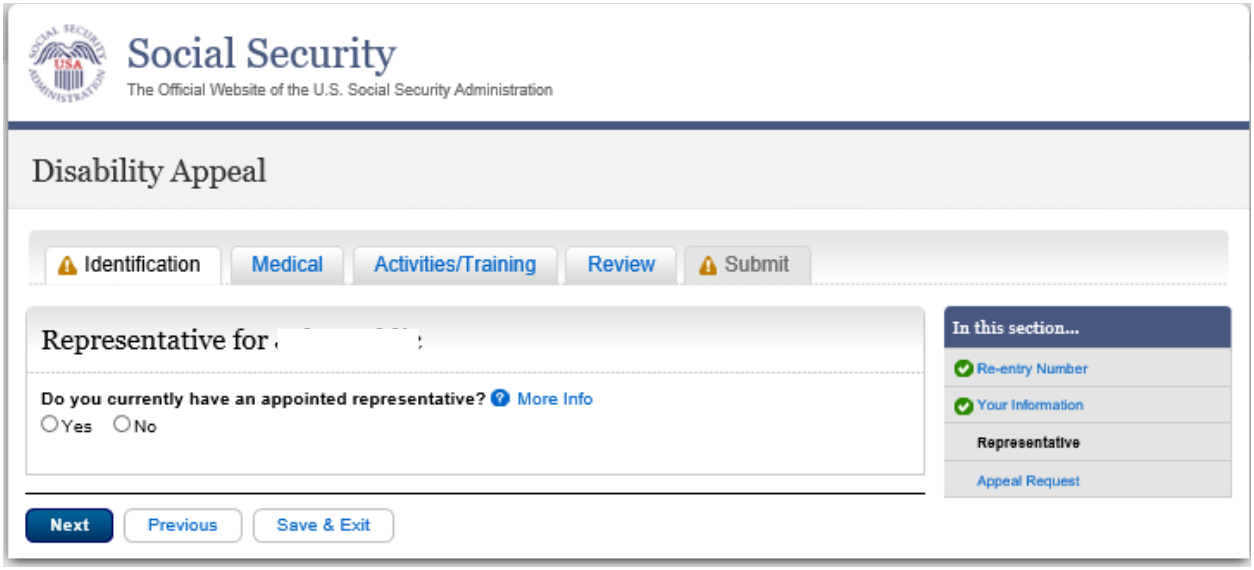
I3441 Screenshots for Claimant and Third party

Claimant

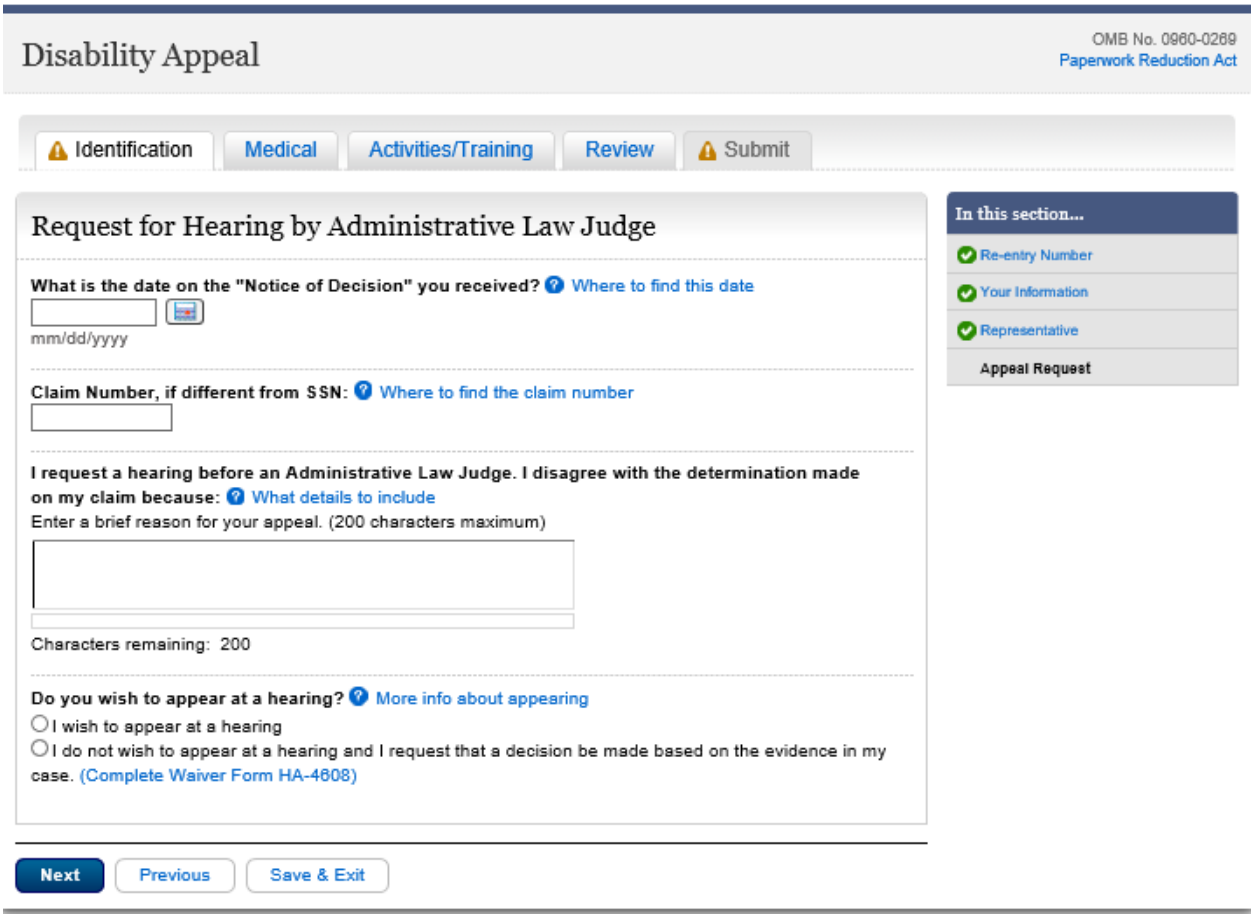
About you



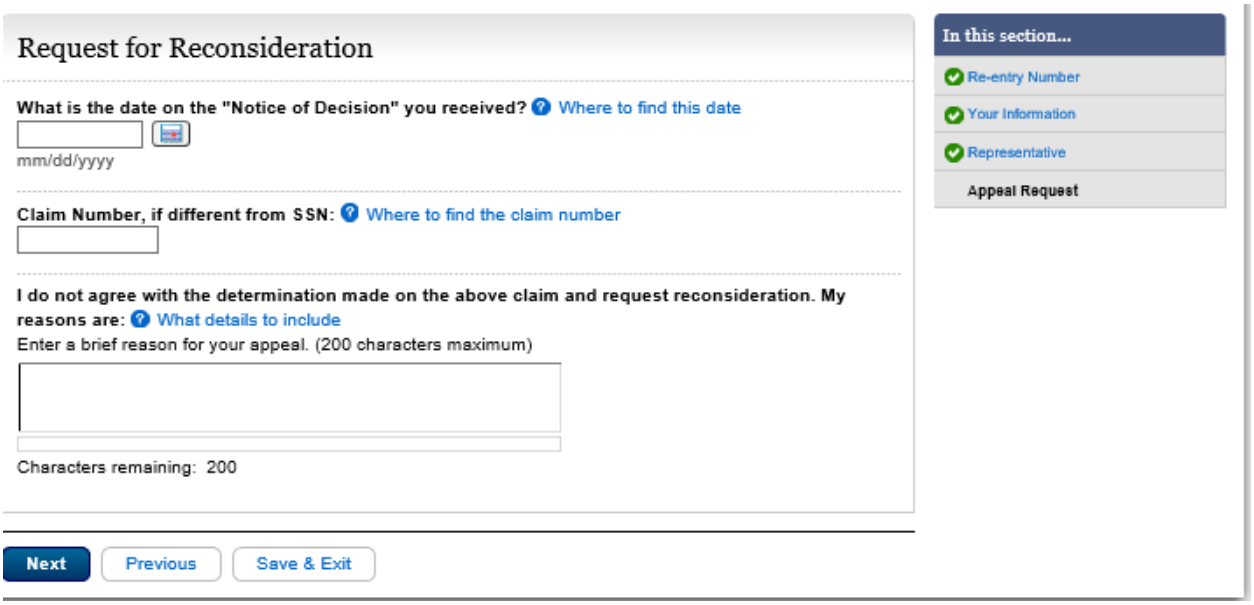
Appointed Rep



Request for Hearing

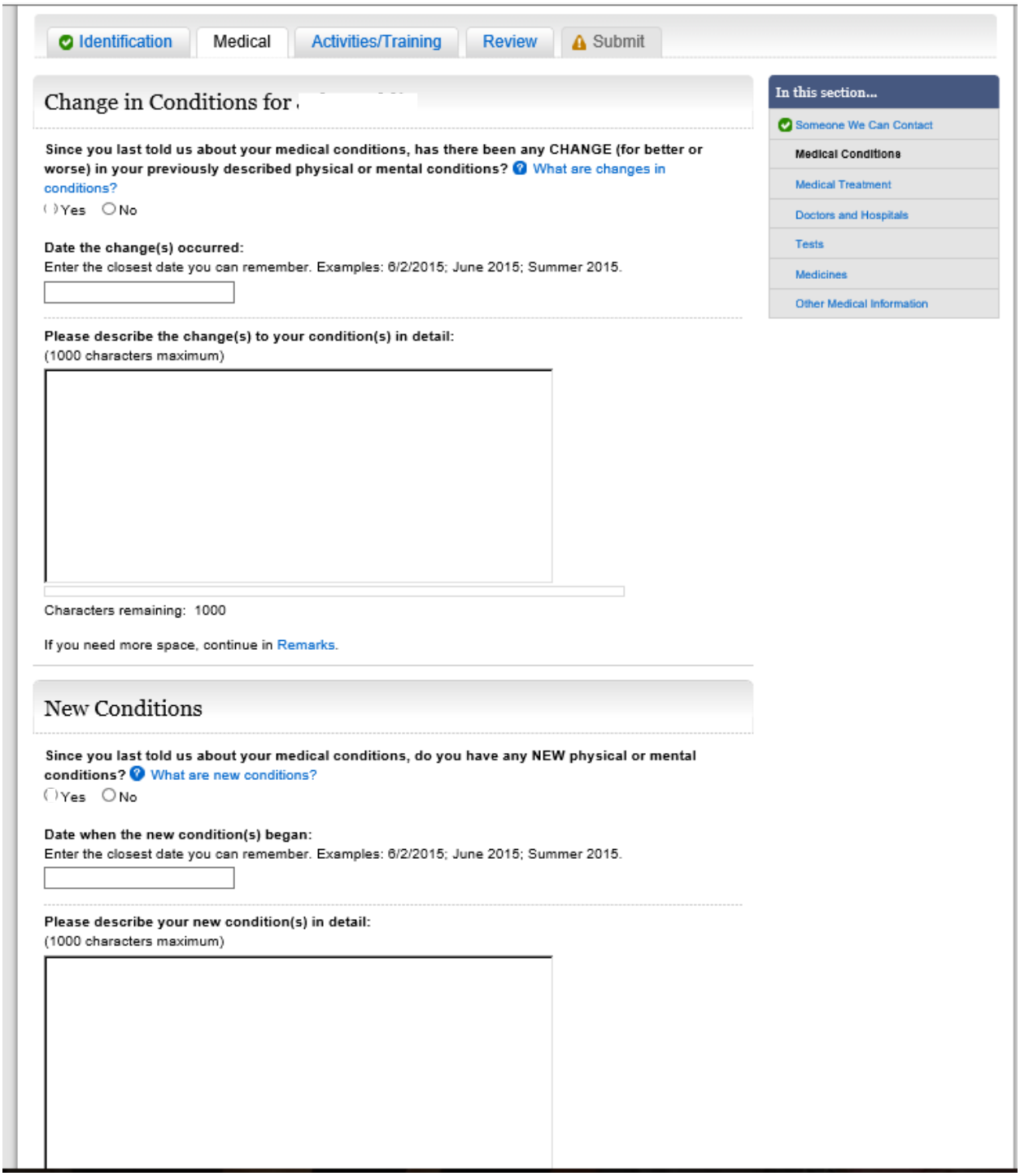


Request for Reconsideration



Contacts

Medical Conditions



Characters remaining: 1000

If you need more space, continue in Remarks.

New Conditions

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? What are new conditions?

Yes No

Date when the new condition(s) began:
Enter the closest date you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

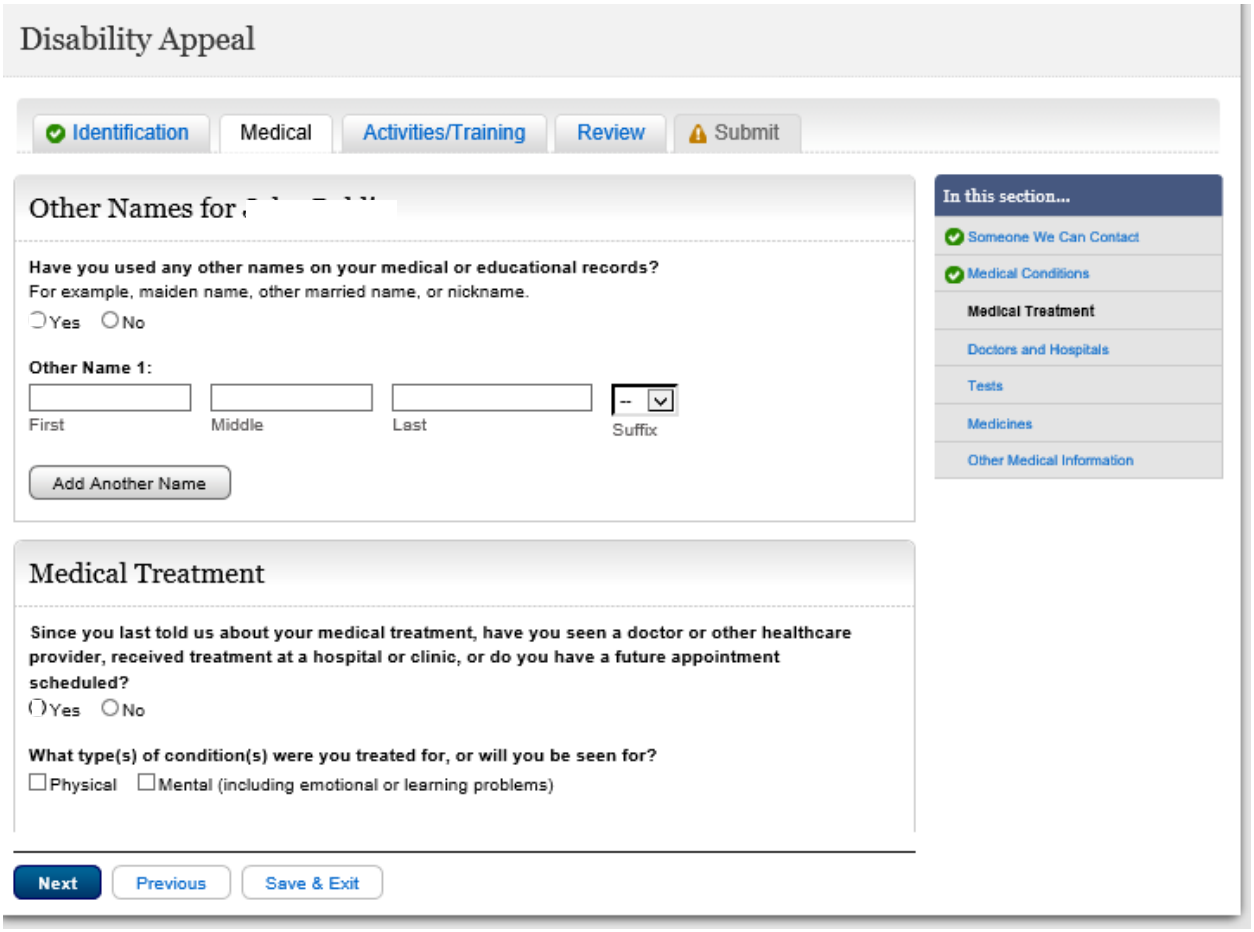
Please describe your new condition(s) in detail:
(1000 characters maximum)

Characters remaining: 1000

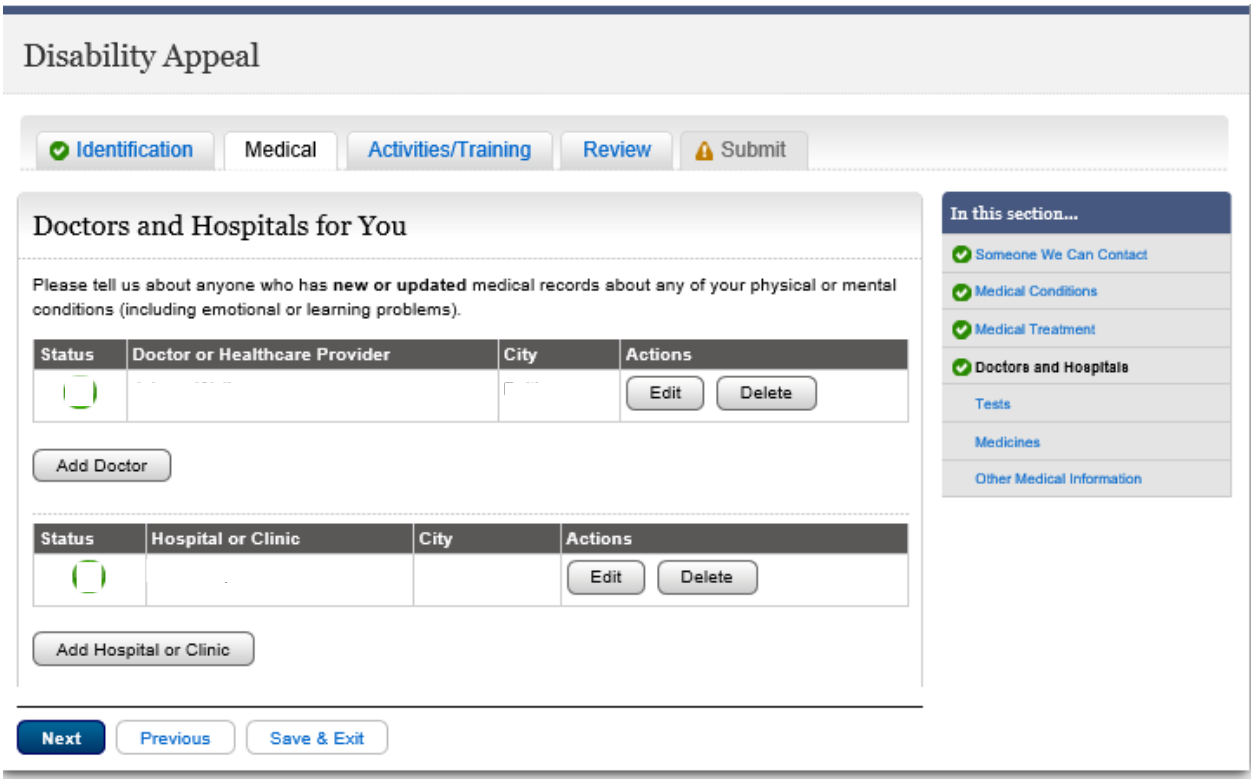
If you need more space, continue in Remarks.

Next Previous Save & Exit

Medical Treatment



Doctors and Hospitals



Doctor or Healthcare Providers

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

-- | First | Last | --

Title | Suffix

Name of Practice or Medical Group:

Phone Number:

U.S. International

10-digit Number | Ext

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: **State/Territory:** **ZIP Code:**

--

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did you receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

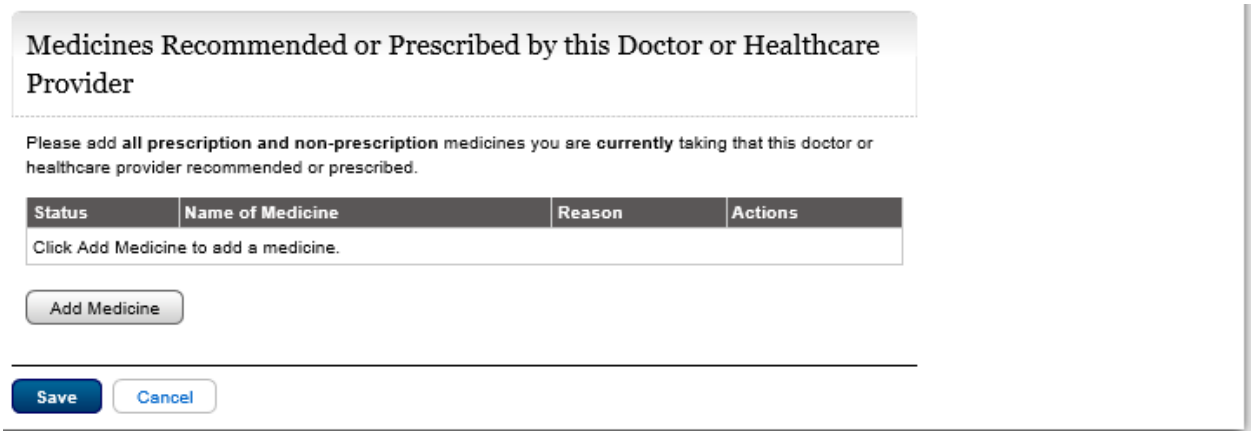
Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

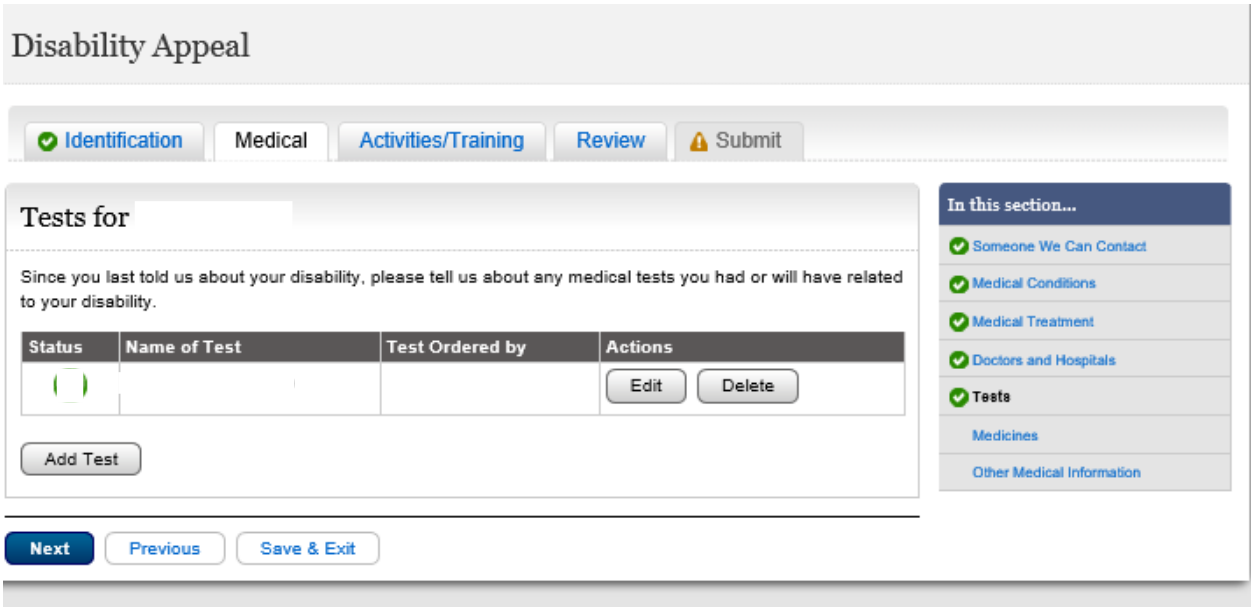
Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click Add Test to add a test.		

Add Test


Medicines Recommended or Prescribed by this Doctor or Healthcare Provider
Please add all prescription and non-prescription medicines you are currently taking that this doctor or healthcare provider recommended or prescribed.
Status
Name of Medicine
Reason
Actions
Click Add Medicine to add a medicine.
Add Medicine
Save
Cancel

Tests


Disability Appeal
Identification
Medical
Activities/Training
Review
Submit
Tests for
Since you last told us about your disability, please tell us about any medical tests you had or will have related to your disability.
Status
Name of Test
Test Ordered by
Actions
Edit
Delete
Add Test
In this section...
Someone We Can Contact
Medical Conditions
Medical Treatment
Doctors and Hospitals
Tests
Medicines
Other Medical Information
Next
Previous
Save & Exit

Hospitals or Clinic Details

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:

U.S. International

10-digit Number Ext

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: **State/Territory:** **ZIP Code:**

--

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?

Outpatient visit means you went home the same day. This does not include emergency room visits.

Yes No

Did you have any emergency room (ER) visits at this hospital or clinic?

ER visit means you went to the ER and then went home.

Yes No

Did you have an overnight stay at this hospital or clinic?

Yes No

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did you receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

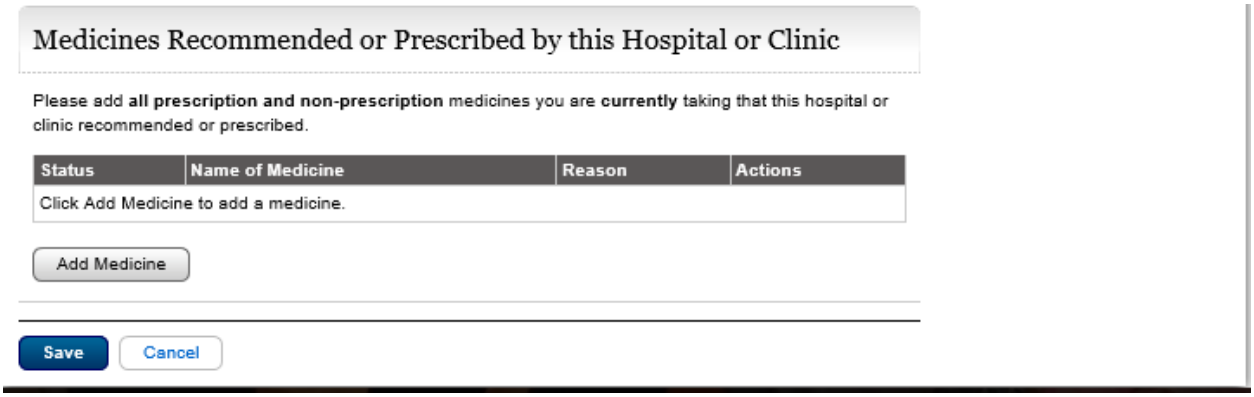
Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

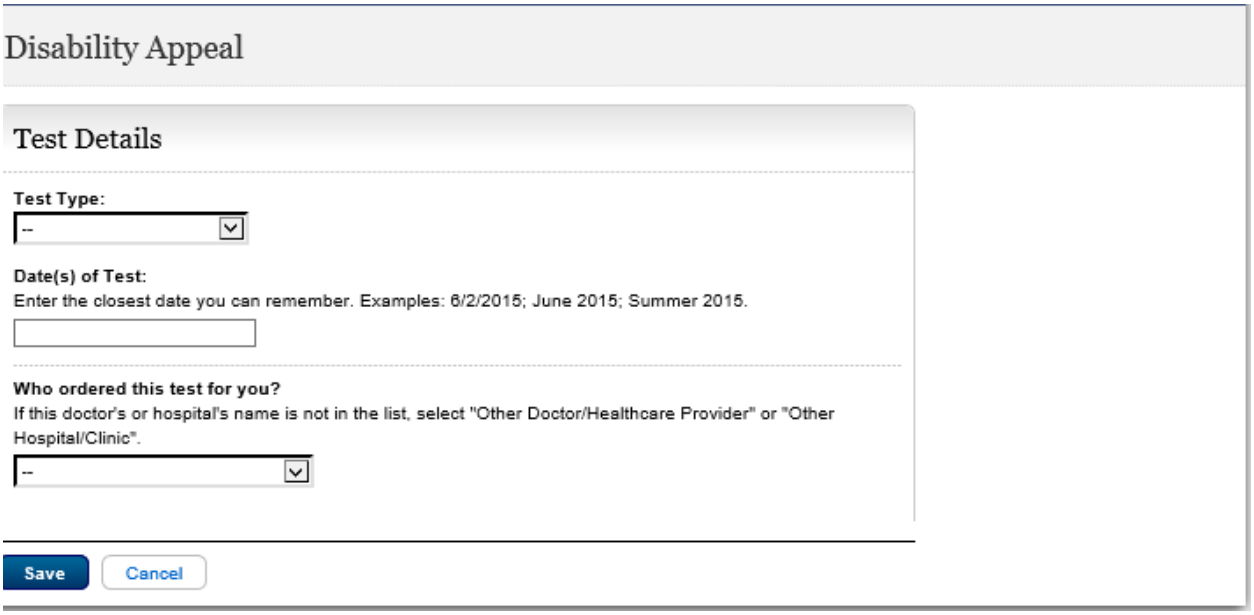
Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click Add Test to add a test.		

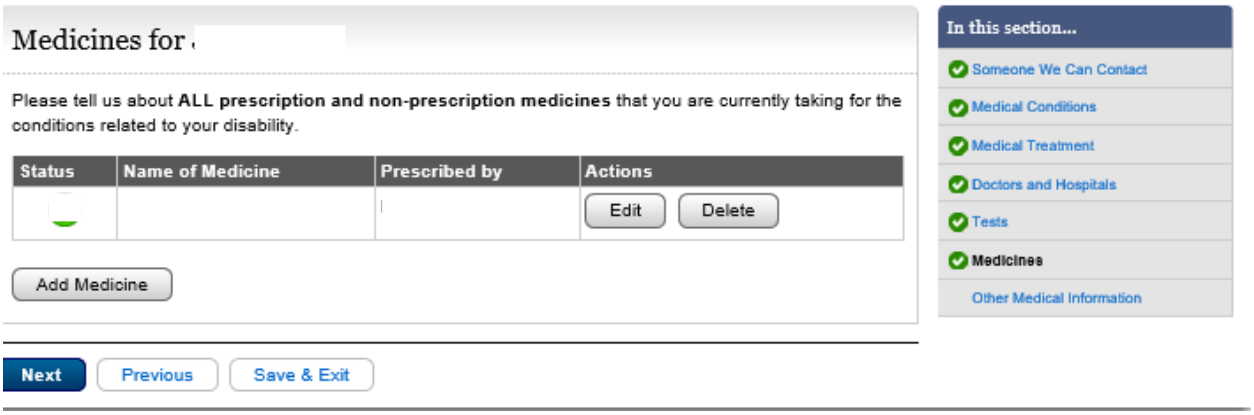
Add Test



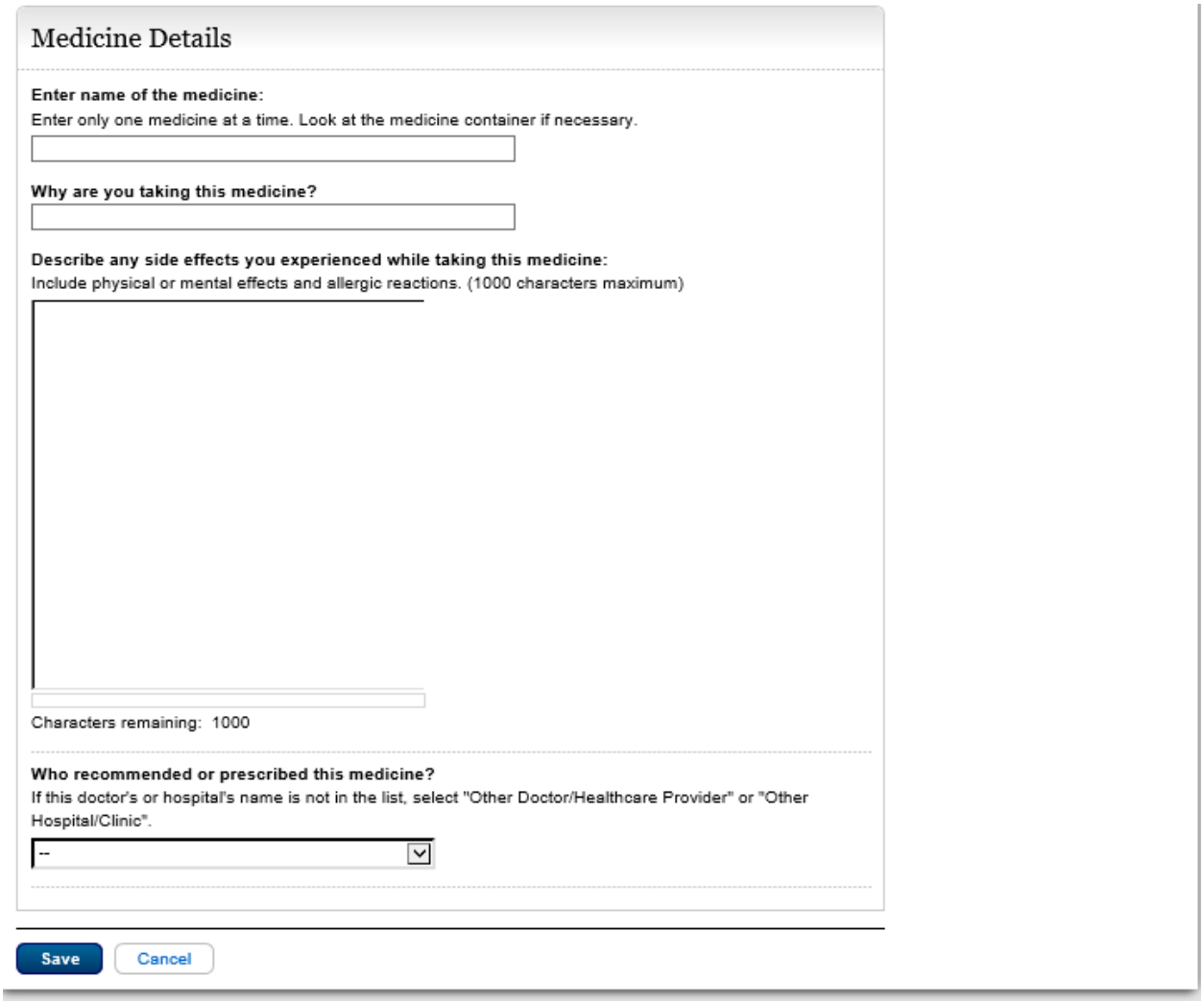
Test Details



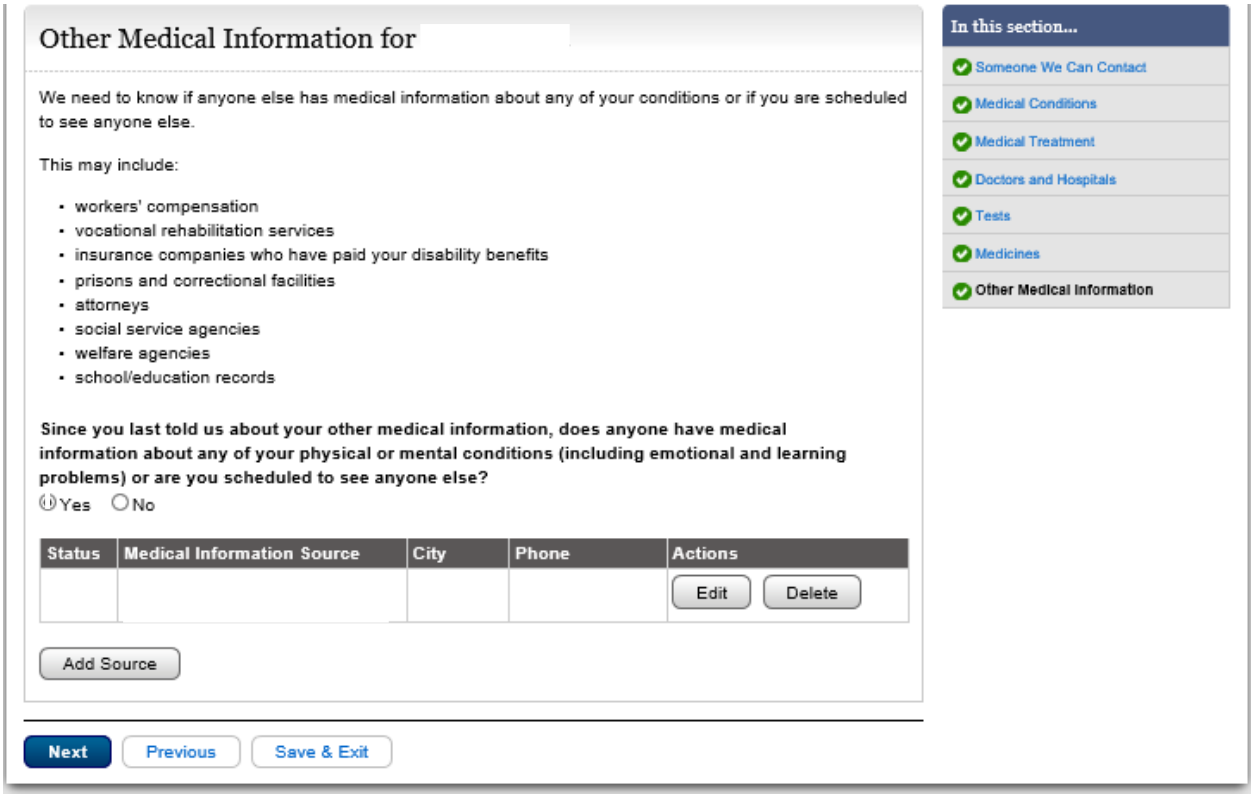
Medicines, Medical



Medicine Details



Other Medical Information



Details of Other Medical Information

Details of Other Medical Information

Name of Organization:

Claim or ID Number, if any:

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: **State/Territory:** **ZIP Code:**

--

Name of Contact Person:

First Last

Phone Number:

U.S. International

10-digit Number Ext

Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor. Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Date of First Contact:

Date of Last Contact:

Date of Next Contact, if any:

Phone Number:

U.S. International

10-digit Number Ext

Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor. Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Date of First Contact:

Date of Last Contact:

Date of Next Contact, if any:

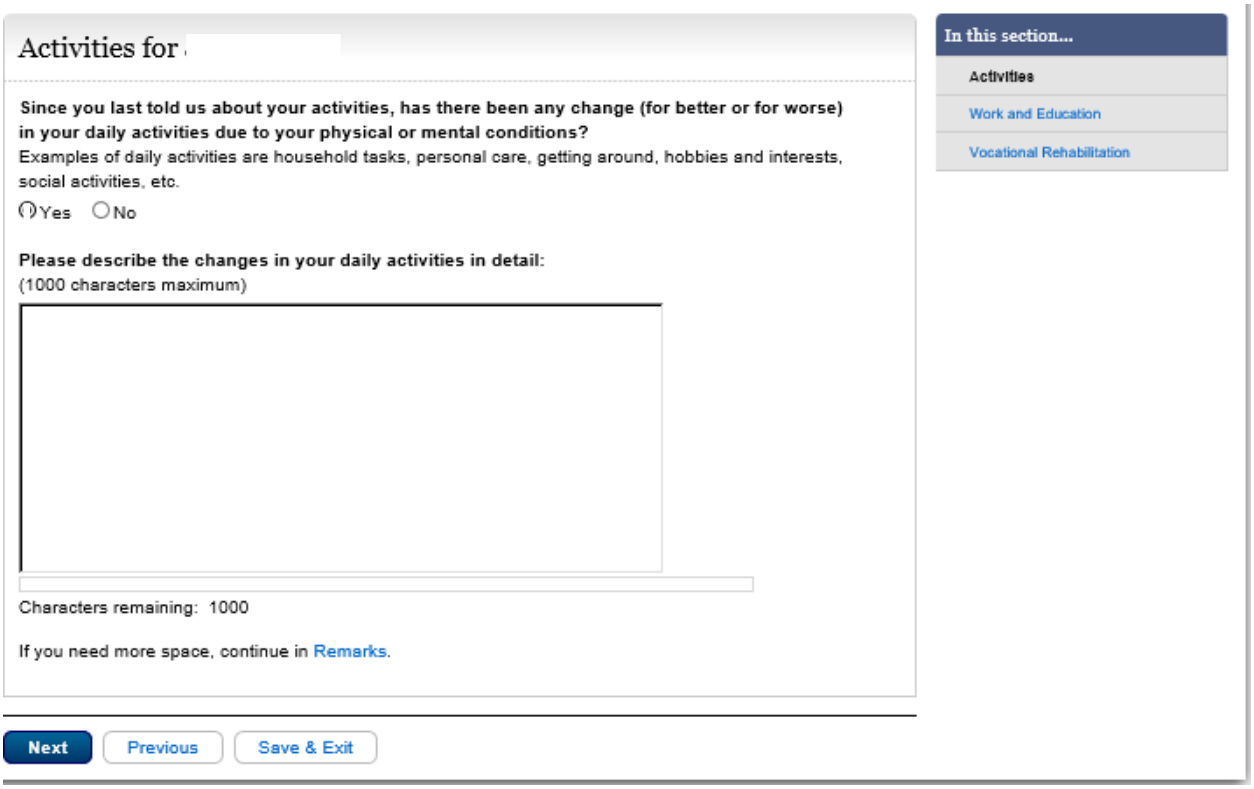
Reasons for Contact:
(1000 characters maximum)

Characters remaining: 1000

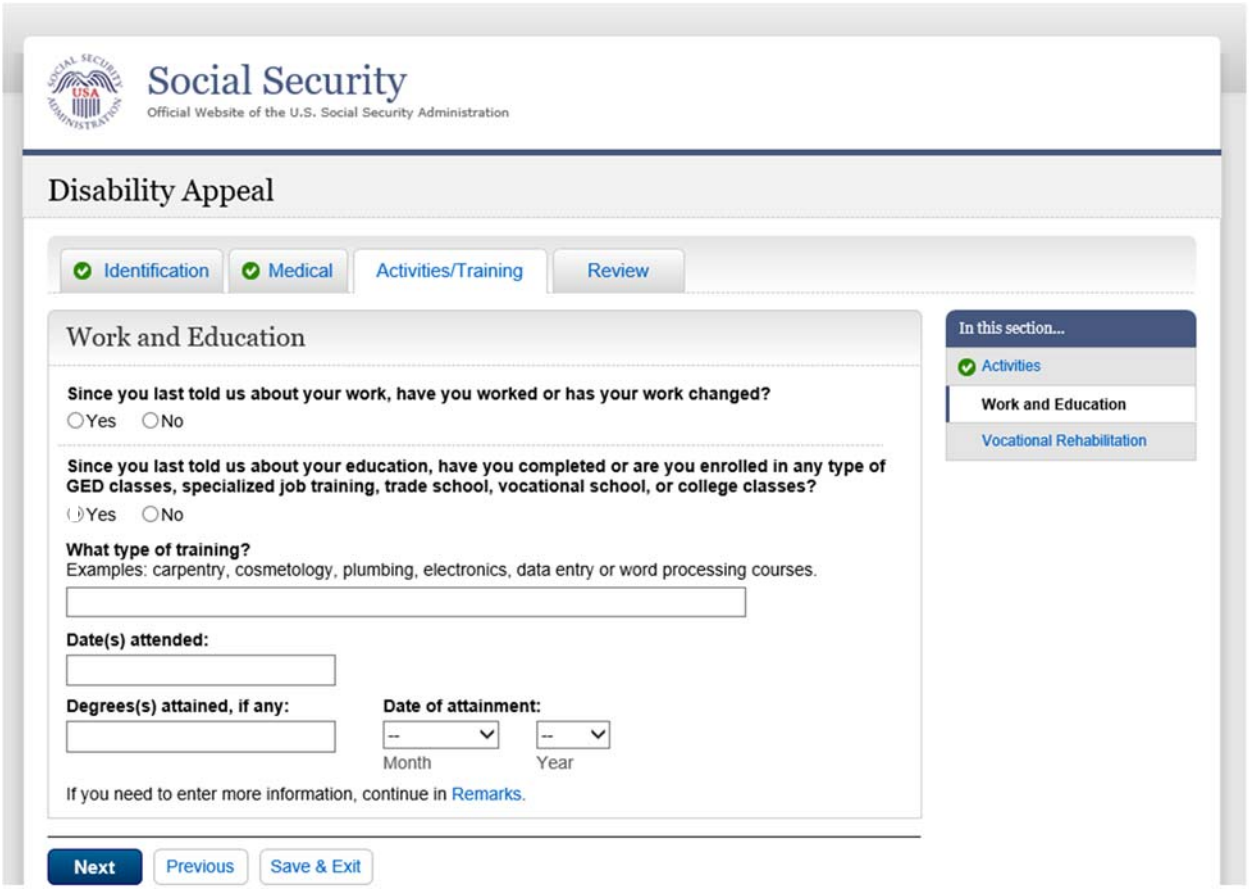
If you need more space, continue in Remarks.

Save Cancel

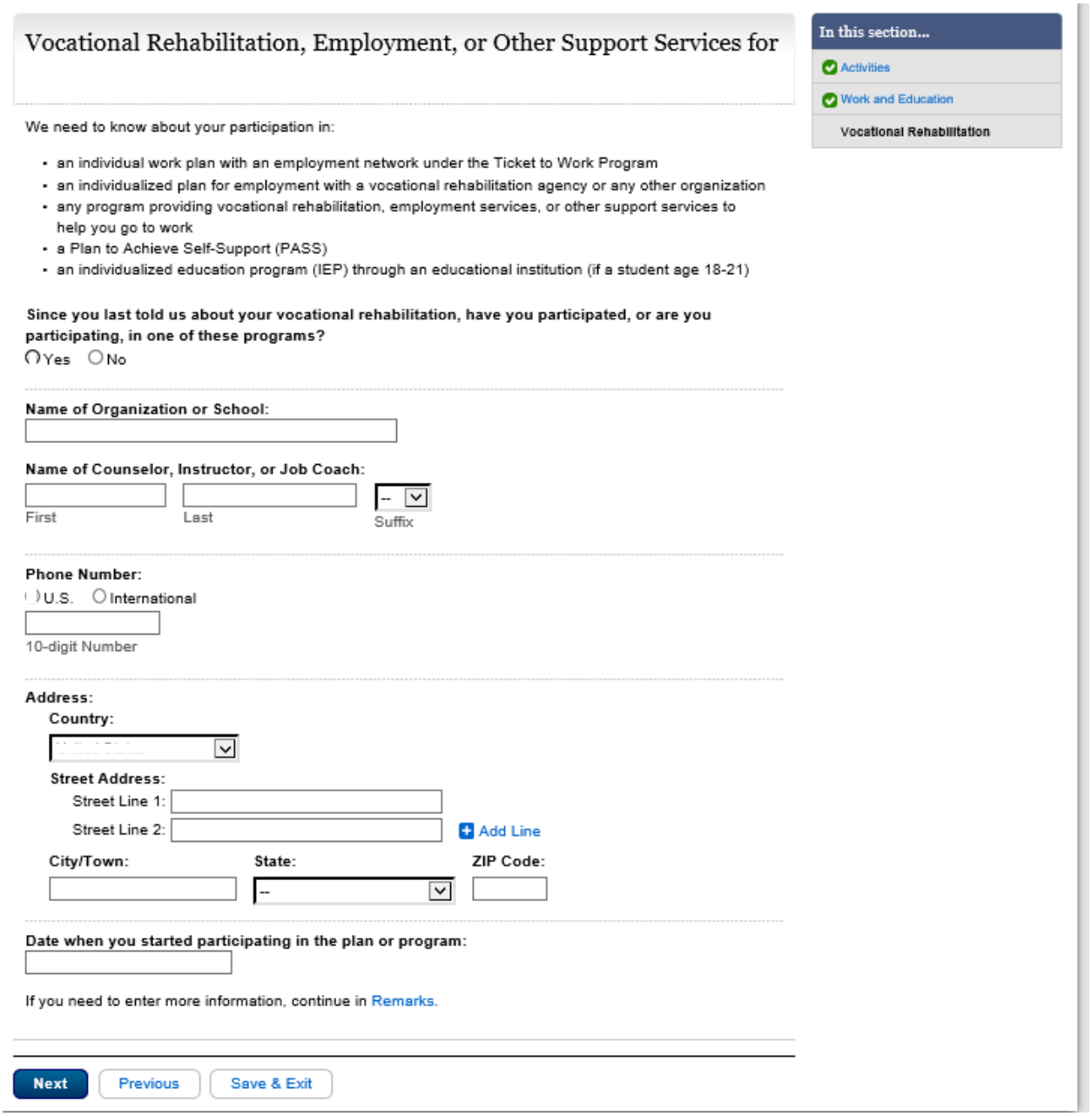
Activities


Activities for
Since you last told us about your activities, has there been any change (for better or for worse) in your daily activities due to your physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.
Yes
No
Please describe the changes in your daily activities in detail:
(1000 characters maximum)
Characters remaining: 1000
If you need more space, continue in Remarks.
Next
Previous
Save & Exit
In this section...
Activities
Work and Education
Vocational Rehabilitation

Work and Education



Voc Rehab



Vocational Rehabilitation, Employment, or Other Support Services for

In this section...
- Activities
- Work and Education
- Vocational Rehabilitation

We need to know about your participation in:

- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18-21)

Since you last told us about your vocational rehabilitation, have you participated, or are you participating, in one of these programs?

Yes No

Name of Organization or School:

Name of Counselor, Instructor, or Job Coach:

First Last Suffix

Phone Number:

U.S. International

10-digit Number

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

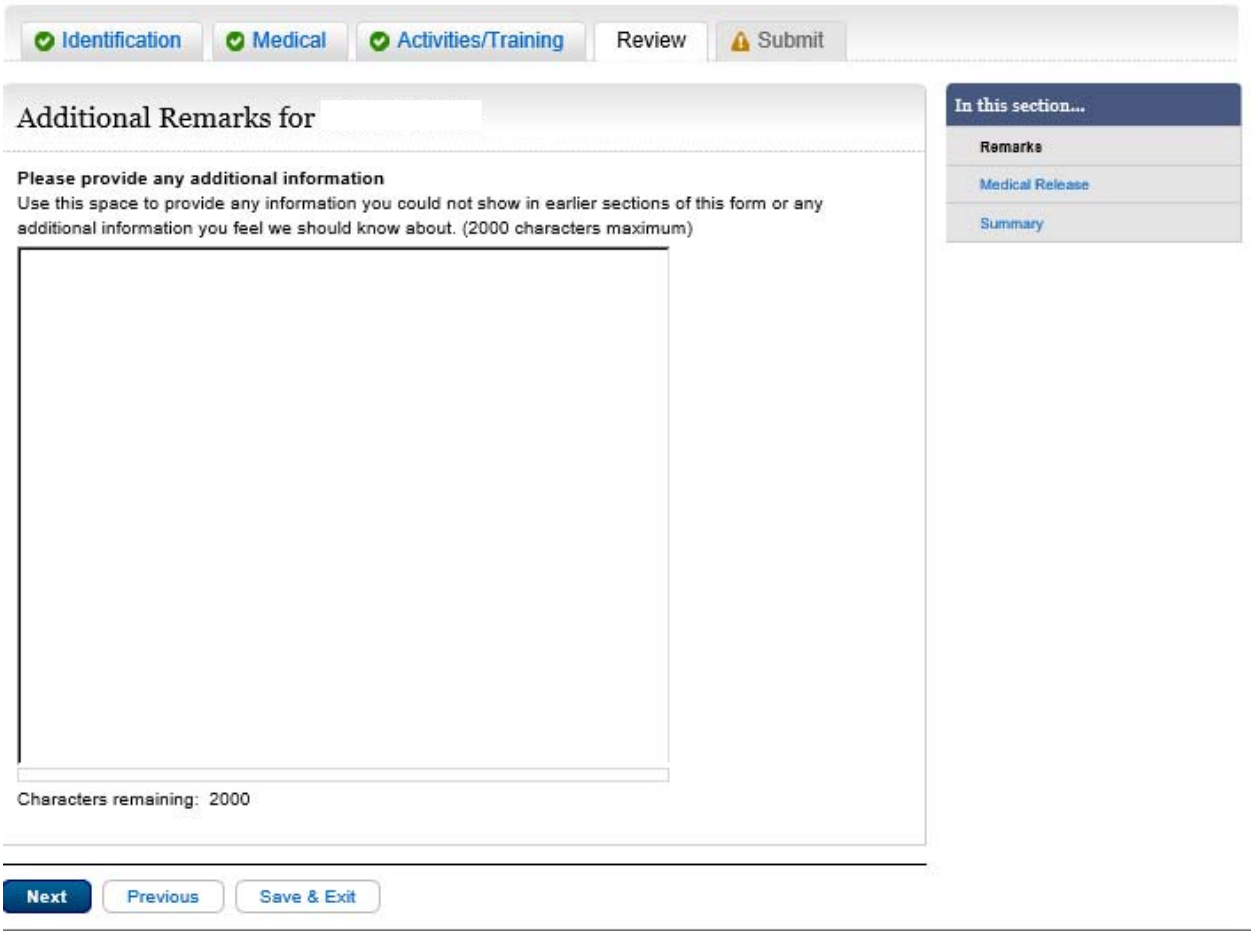
City/Town: **State:** **ZIP Code:**

Date when you started participating in the plan or program:

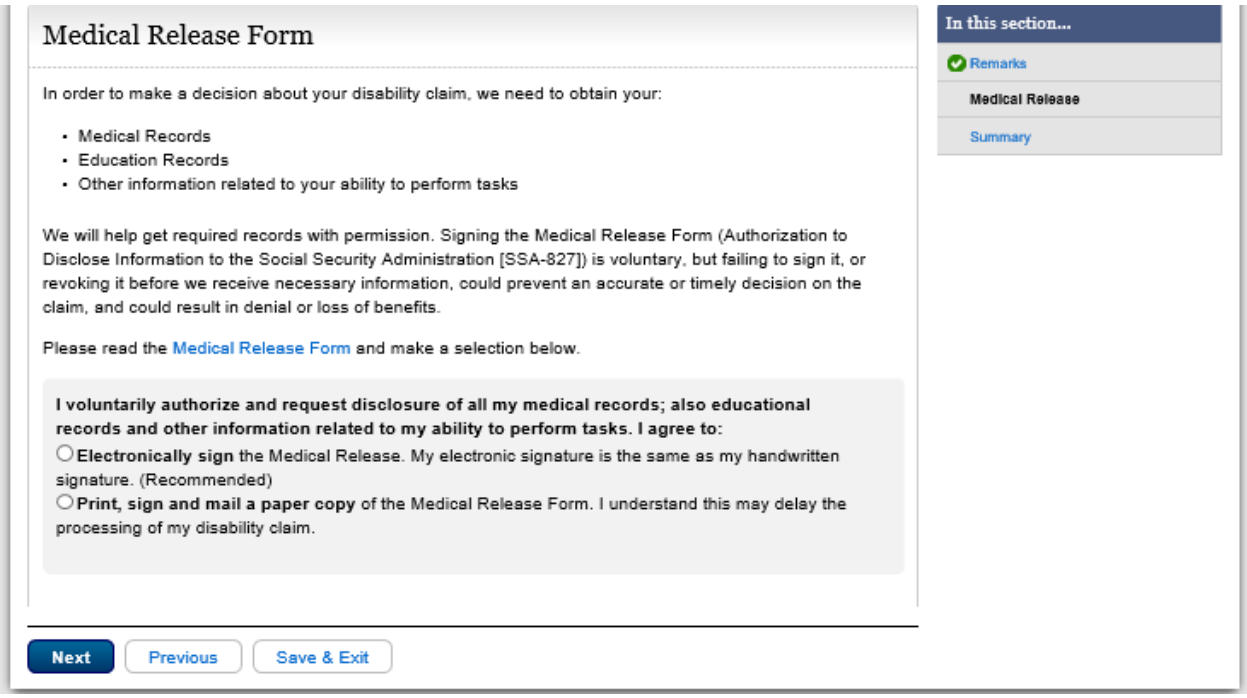
If you need to enter more information, continue in Remarks.

Next Previous Save & Exit

Remarks

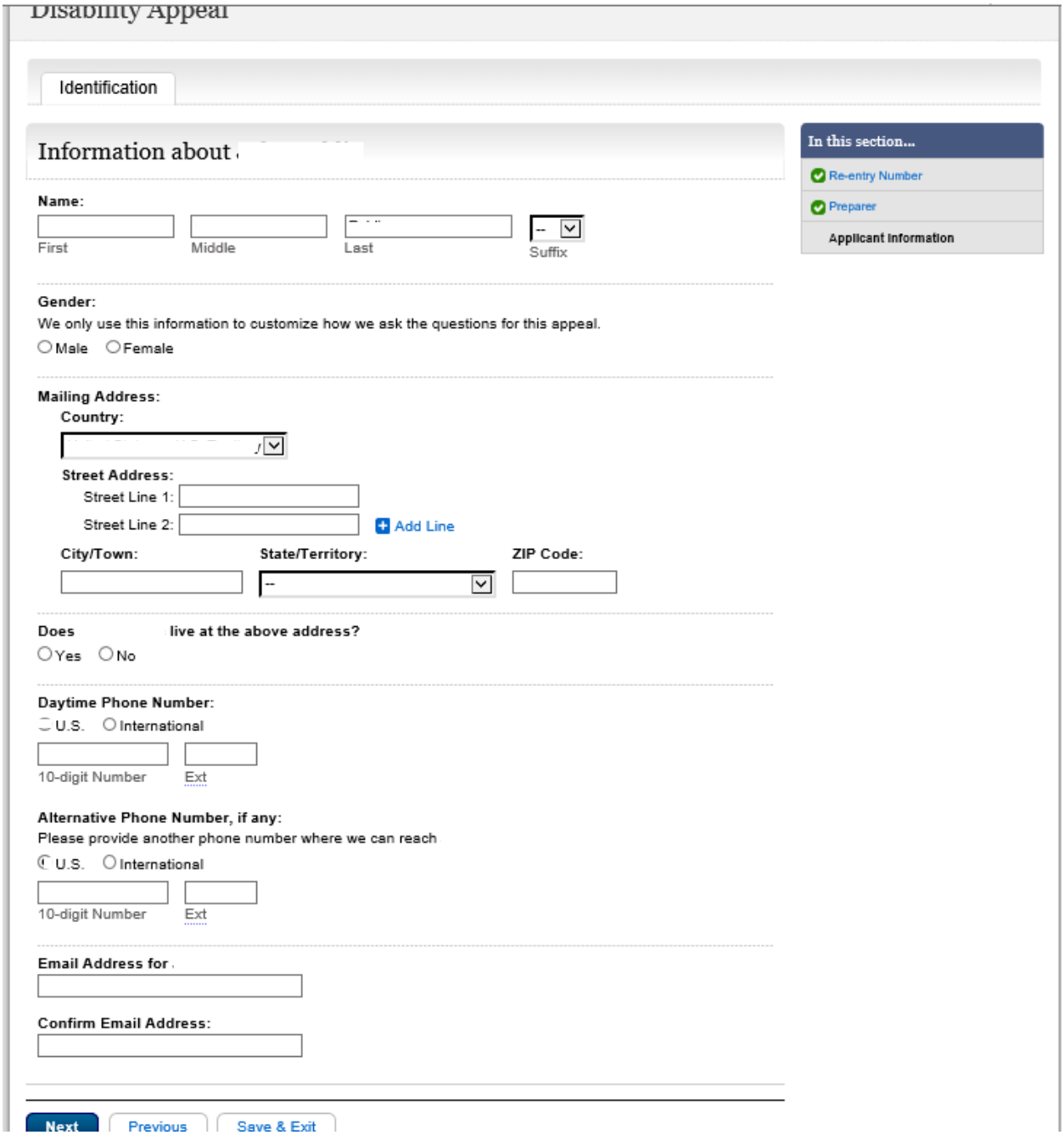

Identification
Medical
Activities/Training
Review
Submit
Additional Remarks for
Please provide any additional information
Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. (2000 characters maximum)
Characters remaining: 2000
In this section...
Remarks
Medical Release
Summary
Next
Previous
Save & Exit

Medical Release

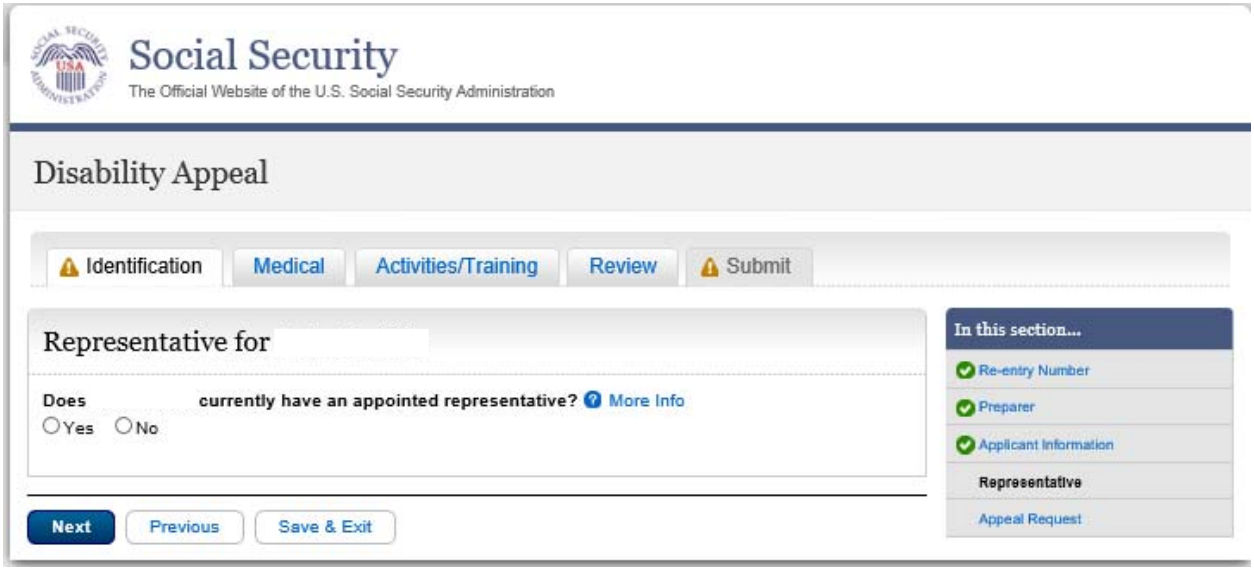


3rd Party

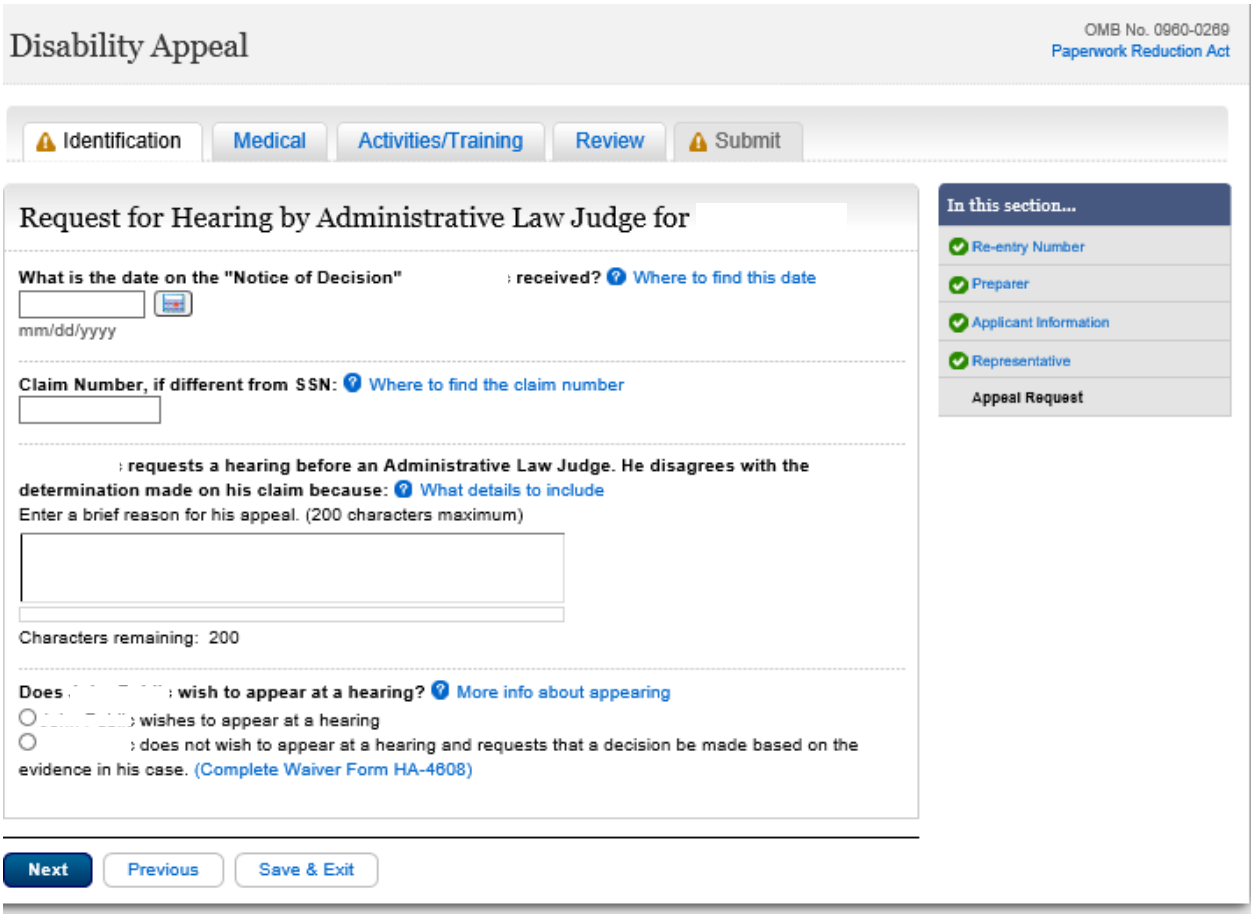
About Applicant



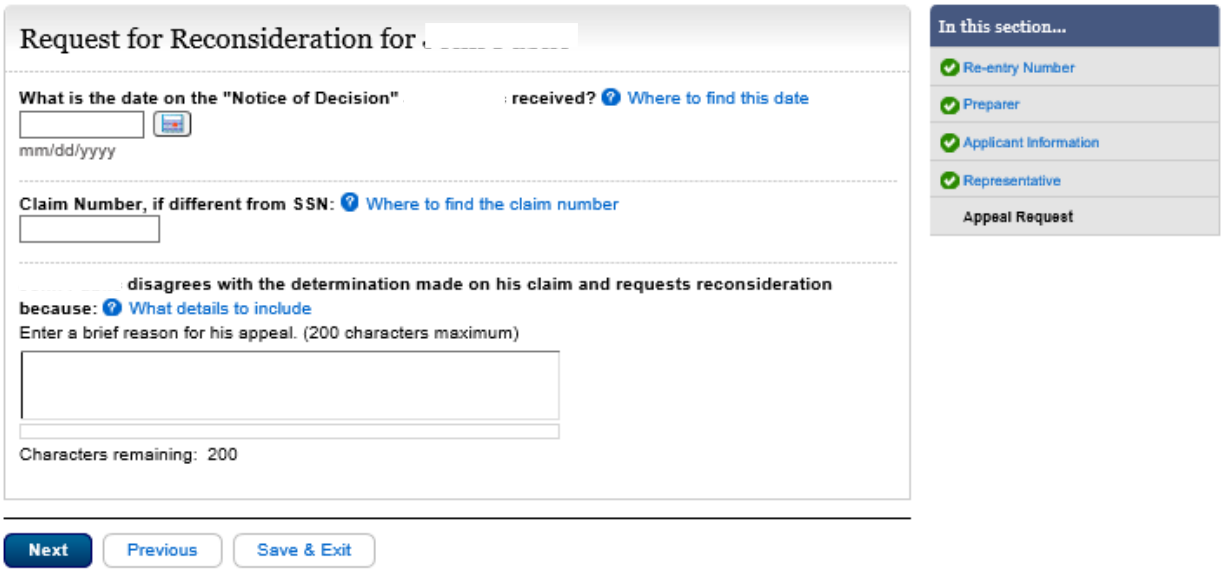
Appointed Rep



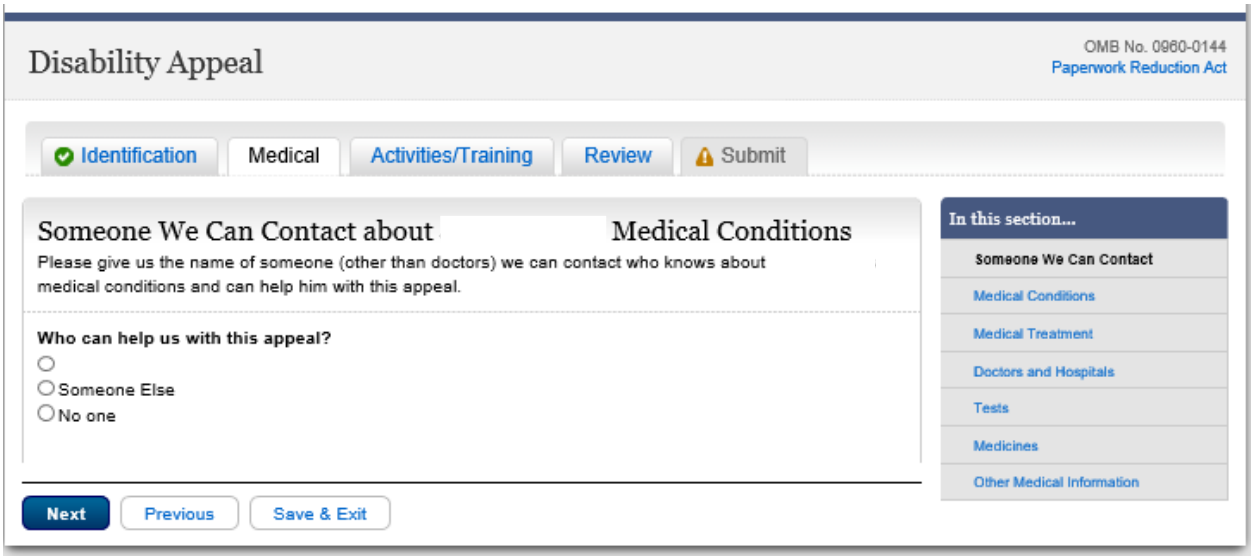
Request for Hearing



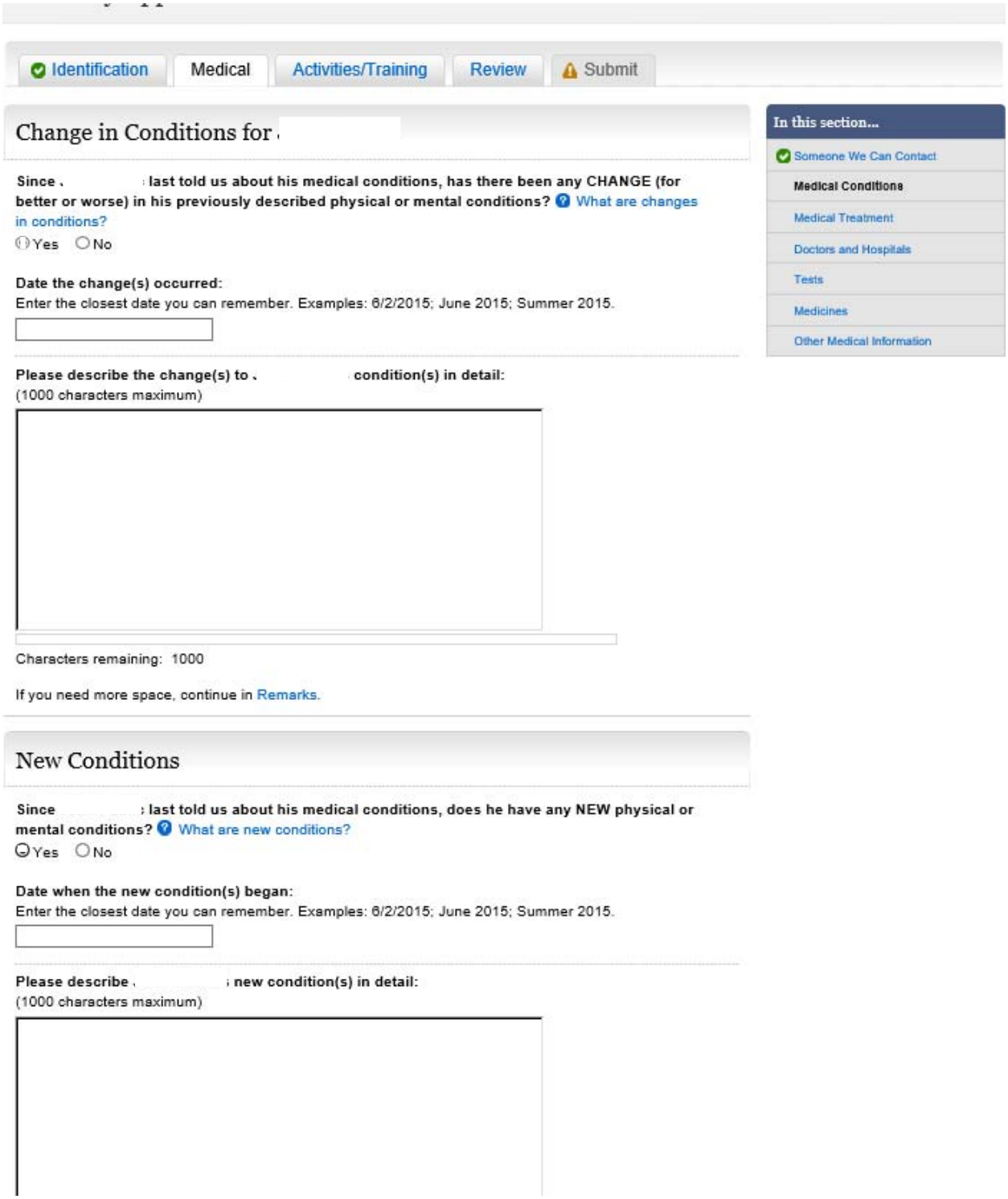
Request for Reconsideration



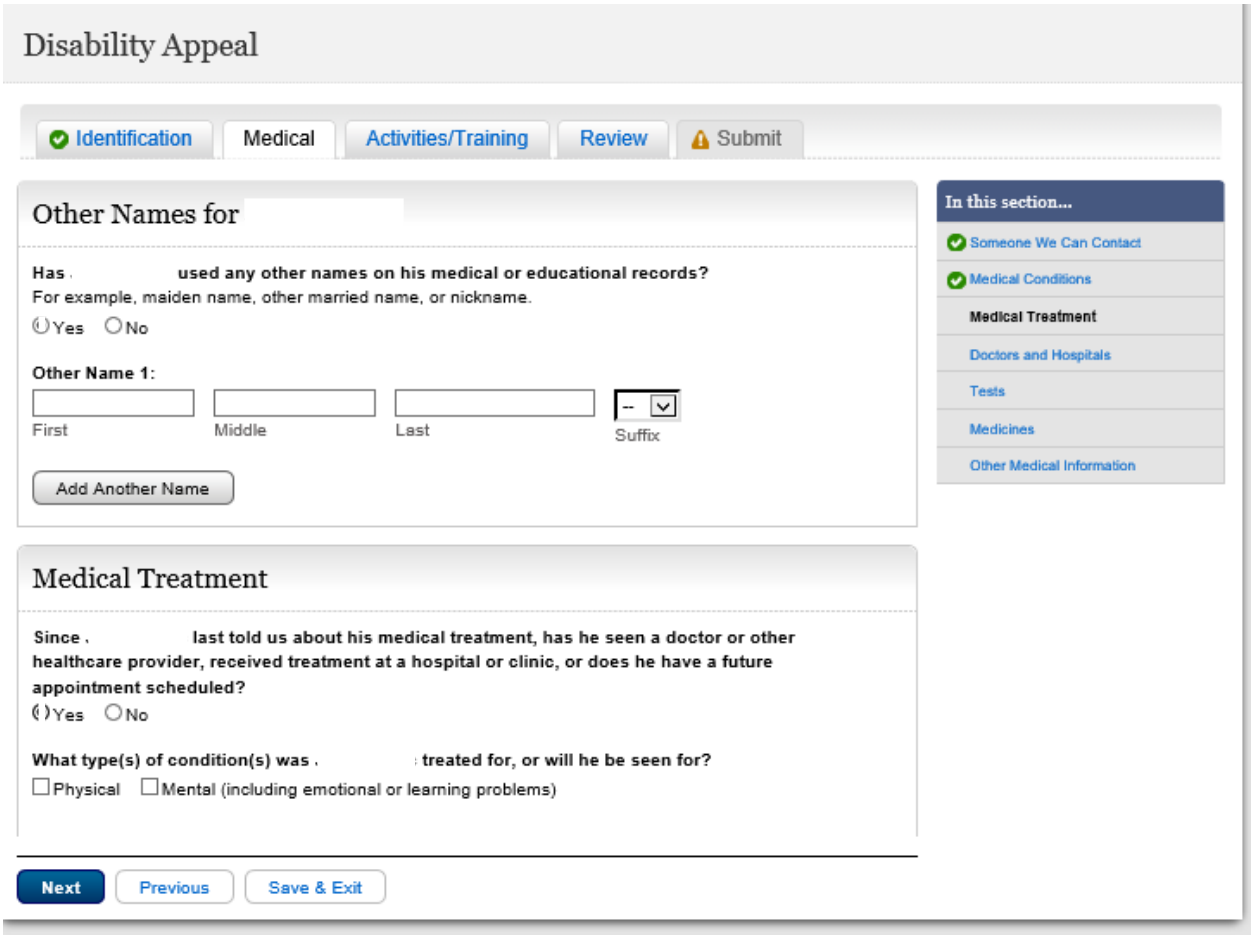
Contacts



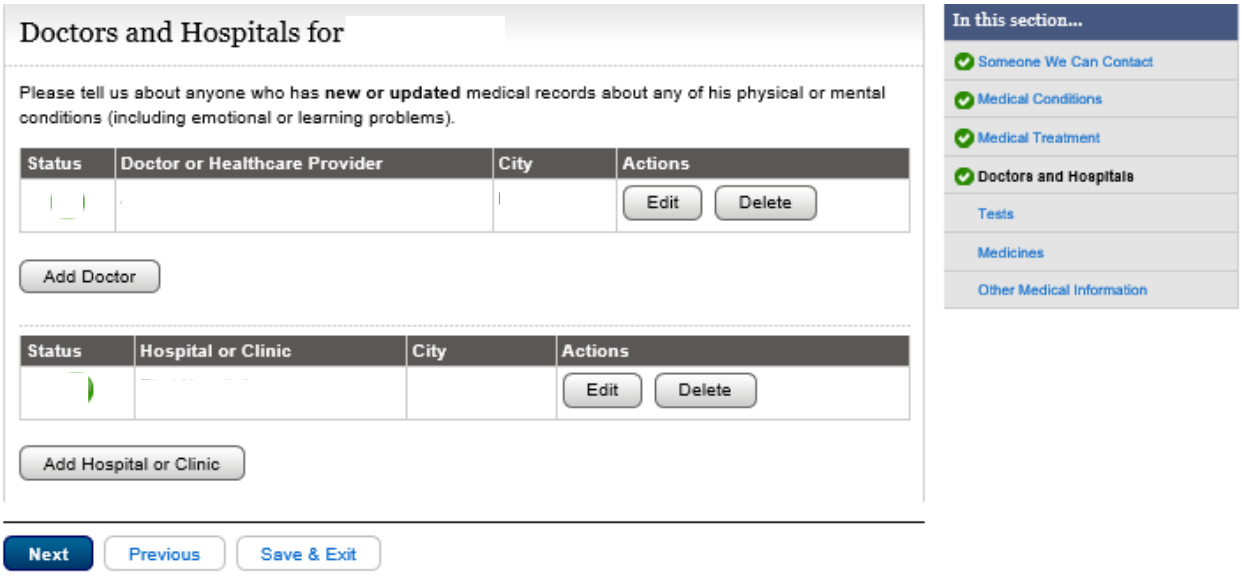
Medical Conditions



Medical Treatment



Doctors and Hospitals



Doctors or Healthcare Provider Details

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

-- | | | --
Title | First | Last | Suffix

Name of Practice or Medical Group:

Phone Number:

U.S. International

10-digit Number | Ext

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: | **State/Territory:** | **ZIP Code:**

--

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Enter the closest date(s) can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What treatment did receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for , including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click Add Test to add a test.		

Add Test

Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

Please add **all prescription and non-prescription** medicines , : is **currently** taking that this doctor or healthcare provider recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

Save Cancel

Hospitals or Clinic Details

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated John Public, if known:

Phone Number:

U.S. International

10-digit Number Ext

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: **State/Territory:** **ZIP Code:**

--

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) , can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did , have any outpatient visits at this hospital or clinic, or does he have any scheduled?

Outpatient visit means he went home the same day. This does not include emergency room visits.

Yes No

First outpatient visit:

Last outpatient visit:

Next scheduled outpatient visit (if any):

Did have any emergency room (ER) visits at this hospital or clinic?
ER visit means he went to the ER and then went home.

(•) Yes ( ) No

Please give the dates of most recent emergency room visits.

Emergency Room Visit 1:

Emergency Room Visit 2:

Emergency Room Visit 3:

Did have an overnight stay at this hospital or clinic?

(•) Yes ( ) No

Give us the dates of John Public's three most recent stays.

Visit 1:

Date In Date Out

Visit 2:

Date In Date Out

Visit 3:

Date In Date Out

Medical Conditions Treated by this Hospital or Clinic

What medical conditions were treated or evaluated by this hospital or clinic?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What treatment did . receive for the above conditions at this hospital or clinic?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for , including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click Add Test to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

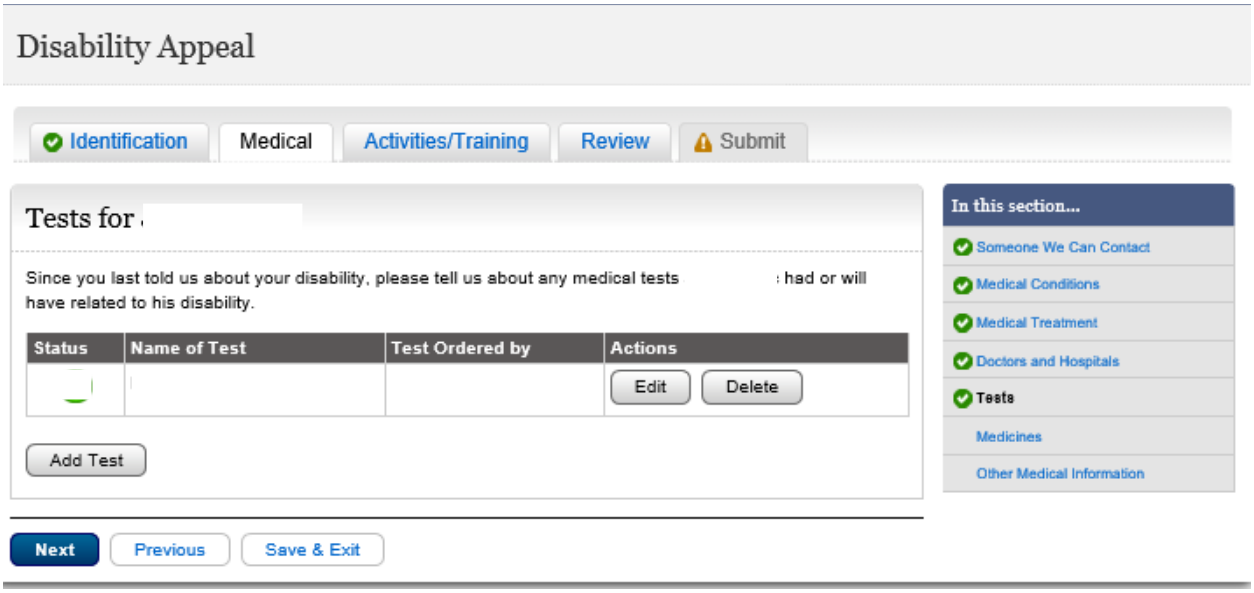
Please add **all prescription and non-prescription** medicines , is **currently** taking that this hospital or clinic recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click Add Medicine to add a medicine.			

Add Medicine

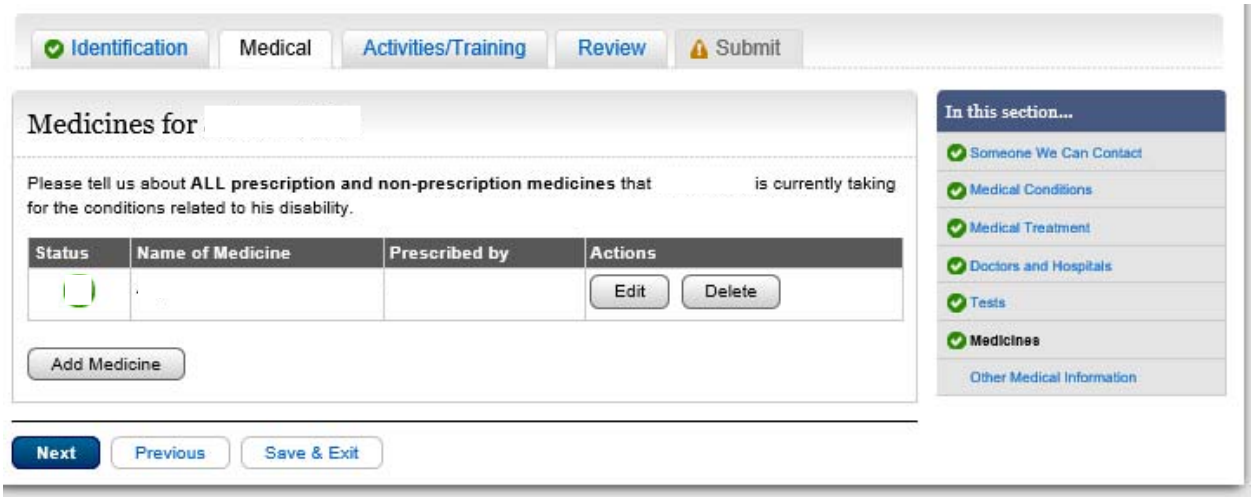
Save Cancel

Tests

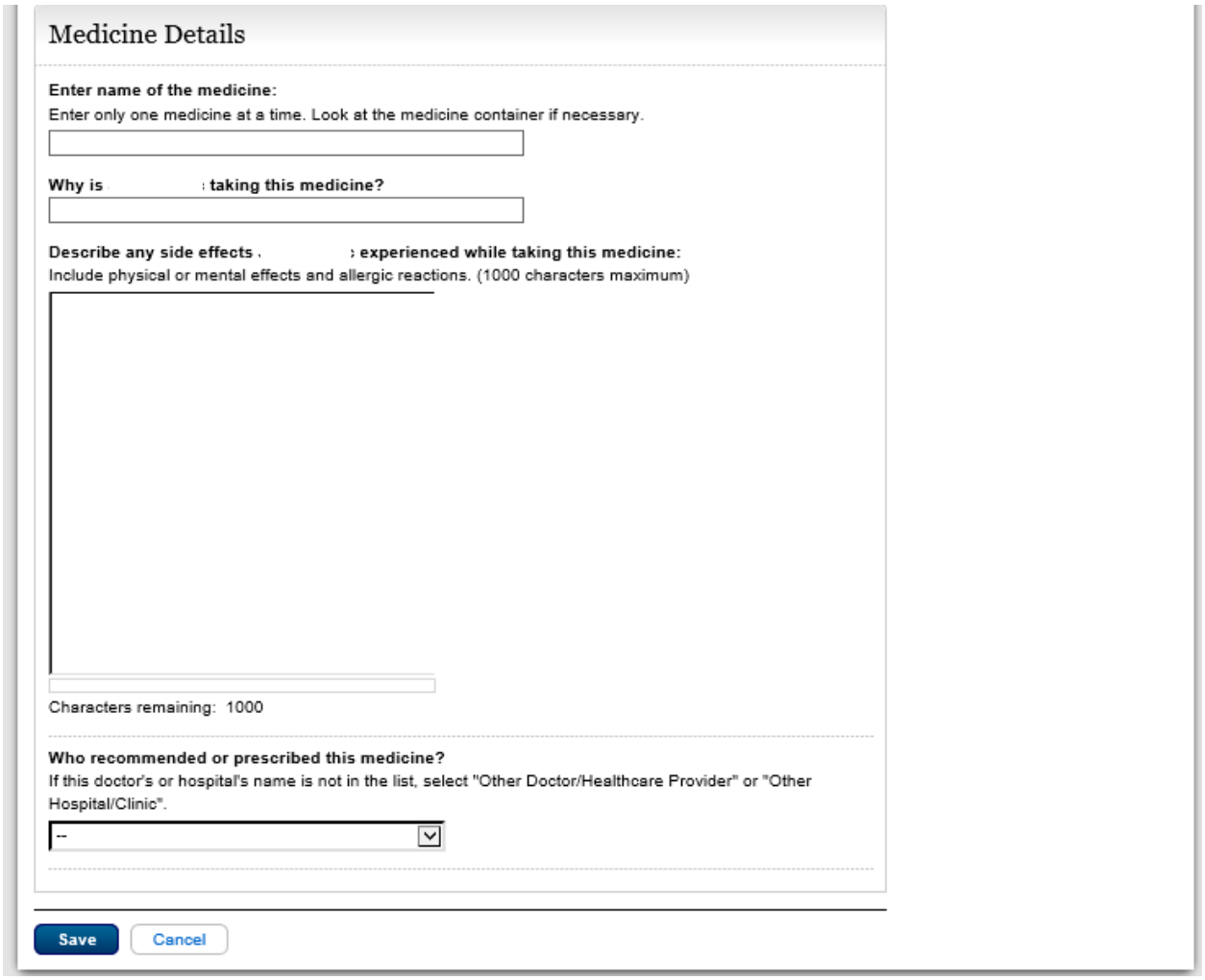


Test Details

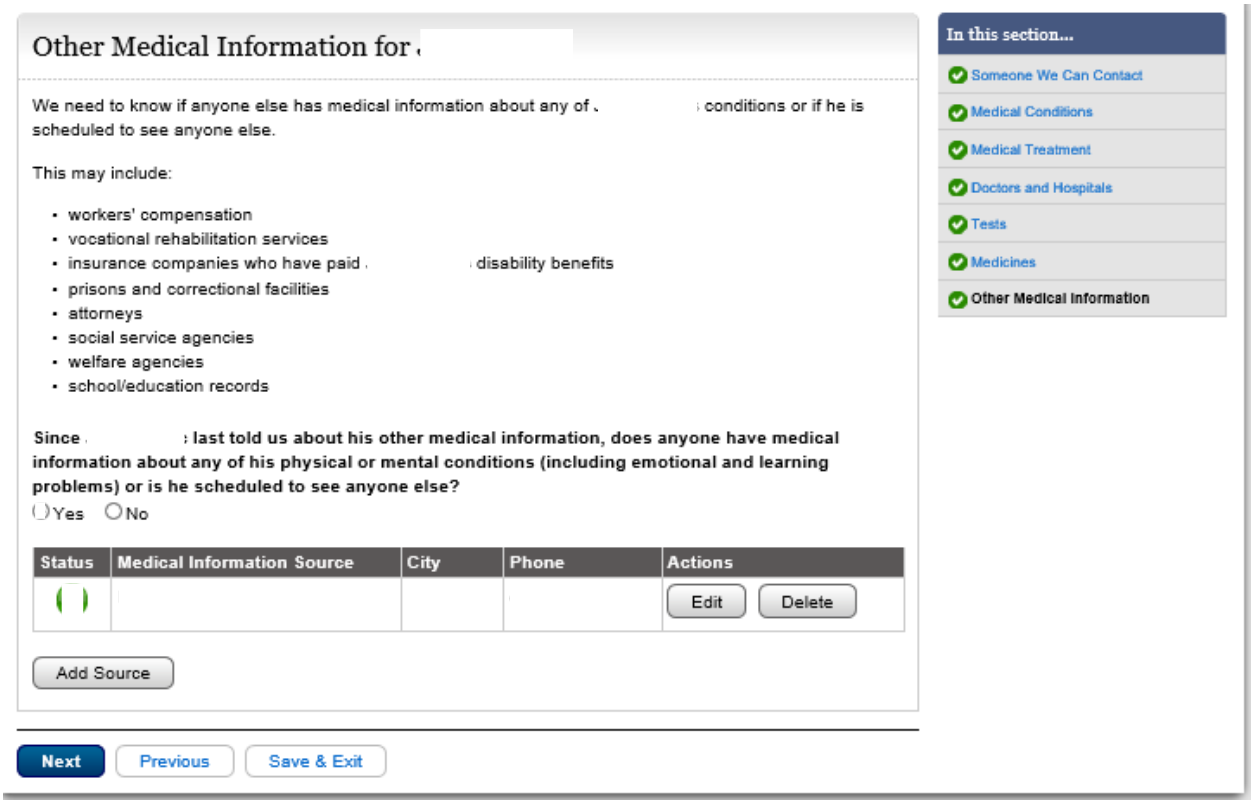
Medicines/Medical



Medicine details



Other Medical Information



Details of Other Medical Information

Details of Other Medical Information

Name of Organization:

Claim or ID Number, if any:

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: **State/Territory:** **ZIP Code:**

--

Name of Contact Person:

First Last

Phone Number:

U.S. International

10-digit Number Ext

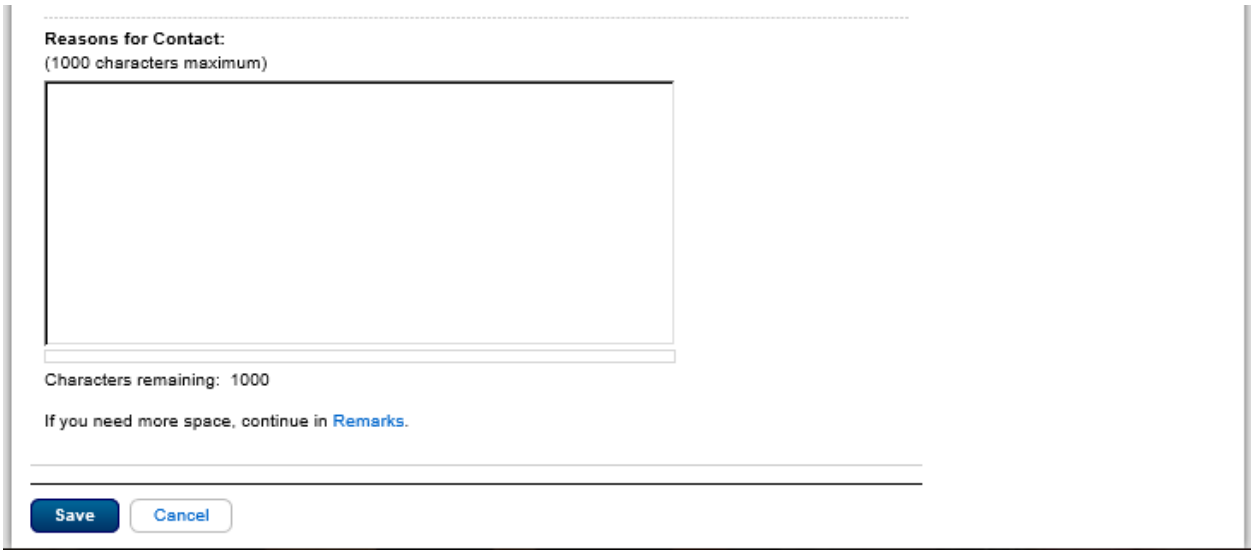
Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor. Enter the closest date(s) can remember. Examples: 6/2/2015; June 2015; Summer 2015.

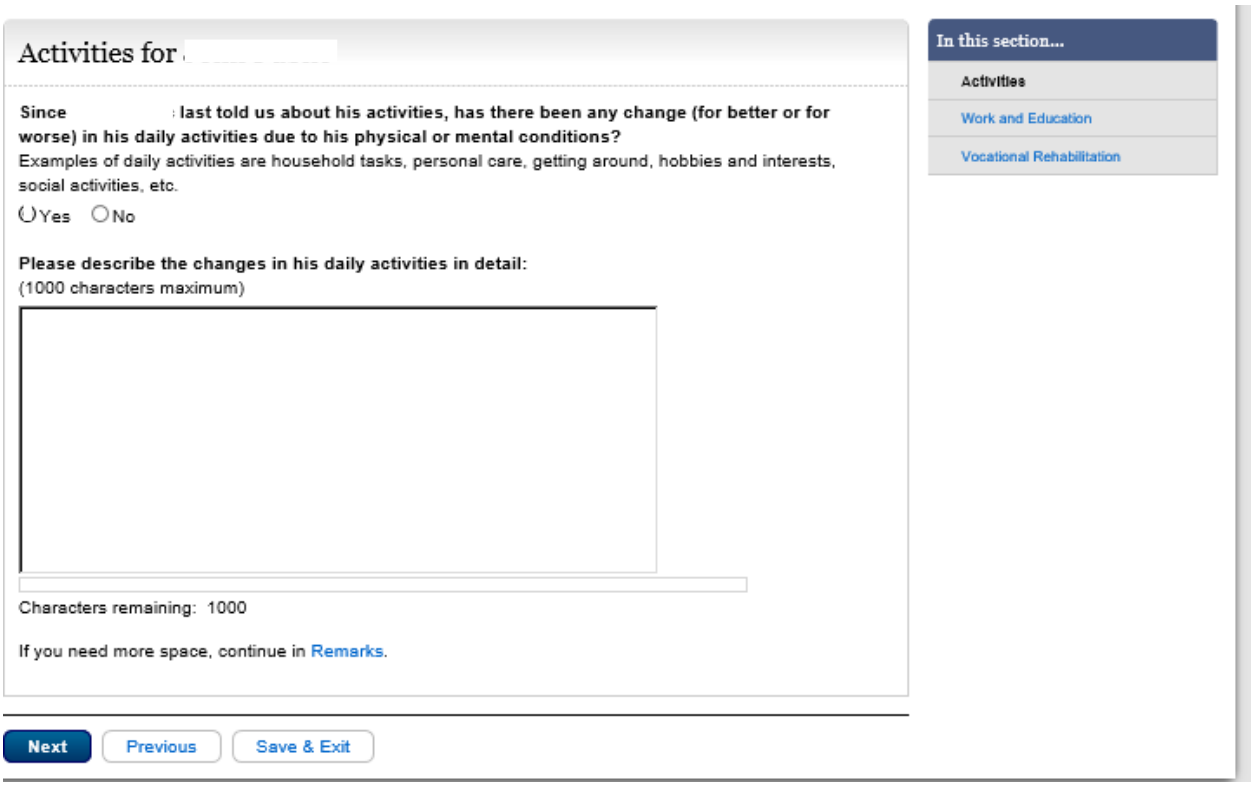
Date of First Contact:

Date of Last Contact:

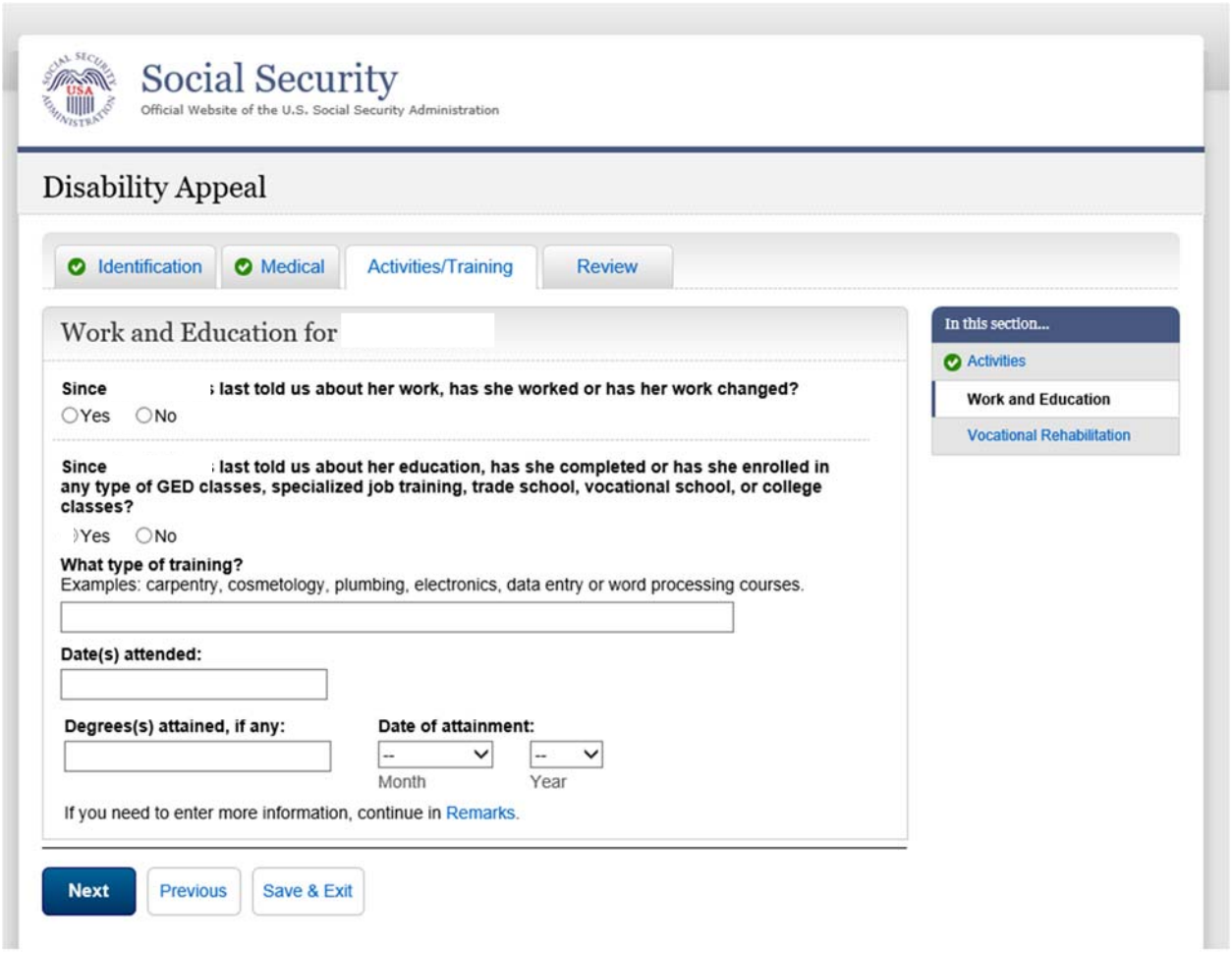
Date of Next Contact, if any:


Reasons for Contact:
(1000 characters maximum)
Characters remaining: 1000
If you need more space, continue in Remarks.
Save
Cancel

Activities


Activities for
Since : last told us about his activities, has there been any change (for better or for worse) in his daily activities due to his physical or mental conditions?
Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.
Yes
No
Please describe the changes in his daily activities in detail:
(1000 characters maximum)
Characters remaining: 1000
If you need more space, continue in Remarks.
Next
Previous
Save & Exit
In this section...
Activities
Work and Education
Vocational Rehabilitation

Work and Education



Voc Rehab

Vocational Rehabilitation, Employment, or Other Support Services for

In this section...
- Activities
- Work and Education
- Vocational Rehabilitation

We need to know about participation in:

- an individual work plan with an employment network under the Ticket to Work Program
- an individualized plan for employment with a vocational rehabilitation agency or any other organization
- any program providing vocational rehabilitation, employment services, or other support services to help him go to work
- a Plan to Achieve Self-Support (PASS)
- an individualized education program (IEP) through an educational institution (if a student age 18-21)

Since last told us about his vocational rehabilitation, has he participated, or is he participating, in one of these programs?

( ) Yes ( ) No

Name of Organization or School:

Name of Counselor, Instructor, or Job Coach:

First | Last | Suffix

Phone Number:

(•) U.S. ( ) International

10-digit Number

Address:

Country:

Street Address:

Street Line 1:

Street Line 2: Add Line

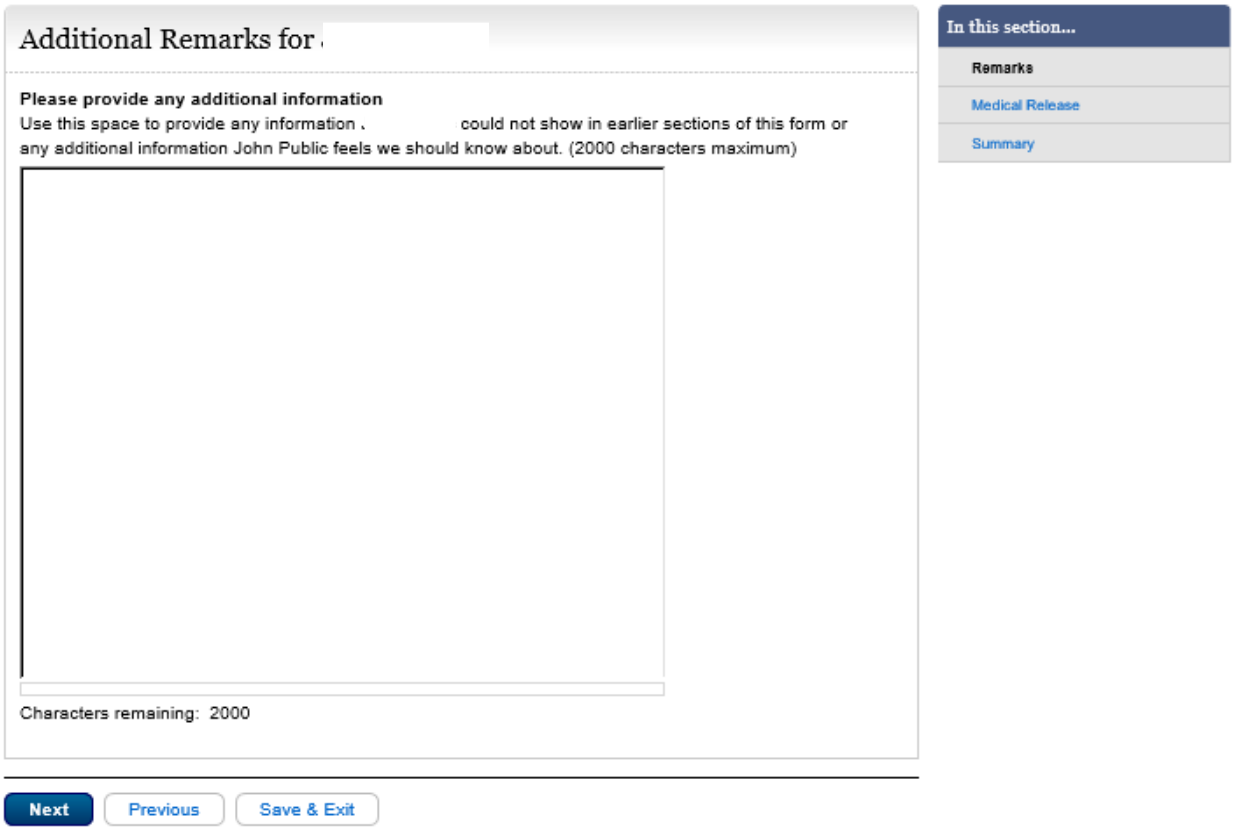
City/Town: **State:** **ZIP Code:**

Date when started participating in the plan or program:

If you need to enter more information, continue in Remarks.

Next | Previous | Save & Exit

Remarks


Additional Remarks for
Please provide any additional information
Use this space to provide any information , could not show in earlier sections of this form or any additional information John Public feels we should know about. (2000 characters maximum)
Characters remaining: 2000
Next
Previous
Save & Exit
In this section...
Remarks
Medical Release
Summary

Medical Release