

About you

Identification

Information about You

In this section...

Re-entry Number

Your information

Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First	Middle	Last	Suffix

Gender:

We only use this information to customize how we ask the questions for this appeal.

Male Female

Mailing Address:

Country:

Street Address:

Street Line 1:

Street Line 2: [+ Add Line](#)

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

Do you live at the above address?

Yes No

Daytime Phone Number:

U.S. International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext

Alternative Phone Number, if any:

Please provide another phone number where we can reach you.

U.S. International

<input type="text"/>	<input type="text"/>
10-digit Number	Ext

Email Address:

Confirm Email Address:

Appointed Rep



Social Security
The Official Website of the U.S. Social Security Administration

Disability Appeal

⚠ Identification **Medical** Activities/Training Review ⚠ Submit

Representative for _____ ;

Do you currently have an appointed representative? [More Info](#)

Yes No

Next Previous Save & Exit

In this section...

- ✓ Re-entry Number
- ✓ Your Information
- Representative**
- Appeal Request

Request for Hearing


Disability Appeal

OMB No. 0960-0269
Paperwork Reduction Act

⚠ Identification **Medical** Activities/Training Review ⚠ Submit

Request for Hearing by Administrative Law Judge

What is the date on the "Notice of Decision" you received? [Where to find this date](#)


mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

I request a hearing before an Administrative Law Judge. I disagree with the determination made on my claim because: [What details to include](#)

Enter a brief reason for your appeal. (200 characters maximum)

Characters remaining: 200

Do you wish to appear at a hearing? [More info about appearing](#)

I wish to appear at a hearing

I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. [\(Complete Waiver Form HA-4808\)](#)

Next Previous Save & Exit

In this section...

- ✓ Re-entry Number
- ✓ Your Information
- ✓ Representative
- Appeal Request**

Request for Reconsideration

Request for Reconsideration

What is the date on the "Notice of Decision" you received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

I do not agree with the determination made on the above claim and request reconsideration. My reasons are: [What details to include](#)

Enter a brief reason for your appeal. (200 characters maximum)

Characters remaining: 200

Next

Previous

Save & Exit

In this section...

Re-entry Number

Your Information

Representative

Appeal Request

Contacts

Someone We Can Contact about Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about your medical conditions and can help you with this appeal.

I don't have a contact.

Name:

First

Middle

Last

Suffix

Relationship to you:

Does this person live with you?

Yes No

Does this person have the same daytime phone number as you?

Yes No

Can this person speak and understand English?

Yes No

Next

Previous

Save & Exit

In this section...

Someone We Can Contact

Medical Conditions

Medical Treatment

Doctors and Hospitals

Tests

Medicines

Other Medical Information

Medical Conditions

- Identification
- Medical
- Activities/Training
- Review
- Submit

Change in Conditions for [REDACTED]

Since you last told us about your medical conditions, has there been any **CHANGE** (for better or worse) in your previously described physical or mental conditions? [What are changes in conditions?](#)

Yes No

Date the change(s) occurred:

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

Please describe the change(s) to your condition(s) in detail:

(1000 characters maximum)

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)

In this section...

Someone We Can Contact

Medical Conditions

Medical Treatment

Doctors and Hospitals

Tests

Medicines

Other Medical Information

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

Disability Appeal

[✔ Identification](#) [Medical](#) [Activities/Training](#) [Review](#) [⚠ Submit](#)

Other Names for [REDACTED]

Have you used any other names on your medical or educational records?
For example, maiden name, other married name, or nickname.

Yes No

Other Name 1:

First Middle Last Suffix

[Add Another Name](#)

In this section...

[✔ Someone We Can Contact](#)

[✔ Medical Conditions](#)

Medical Treatment

[Doctors and Hospitals](#)

[Tests](#)

[Medicines](#)

[Other Medical Information](#)

Medical Treatment

Since you last told us about your medical treatment, have you seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled?

Yes No

What type(s) of condition(s) were you treated for, or will you be seen for?

Physical Mental (including emotional or learning problems)

[Next](#)

[Previous](#)

[Save & Exit](#)

Doctors and Hospitals

Disability Appeal

- Identification
- Medical
- Activities/Training
- Review
- Submit

Doctors and Hospitals for You

Please tell us about anyone who has **new or updated** medical records about any of your physical or mental conditions (including emotional or learning problems).

Status	Doctor or Healthcare Provider	City	Actions
			<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Status	Hospital or Clinic	City	Actions
			<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals**
- Tests
- Medicines
- Other Medical Information

Doctor or Healthcare Providers

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>Title</small>	<small>First</small>	<small>Last</small>	<small>Suffix</small>

Name of Practice or Medical Group:

Phone Number:

U.S. International

<input type="text"/>	<input type="text"/>
<small>10-digit Number</small>	<small>Ext</small>

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

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add all **prescription and non-prescription** medicines you are **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

Test Details

Disability Appeal

Test Details

Test Type:

Date(s) of Test:

Enter the closest date you can remember. Examples: 8/2/2015; June 2015; Summer 2015.

Who ordered this test for you?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".


Save

Cancel

Medicines, Medical

Medicines for .

Please tell us about **ALL prescription and non-prescription medicines** that you are currently taking for the conditions related to your disability.

Status	Name of Medicine	Prescribed by	Actions
			<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

[Someone We Can Contact](#)

[Medical Conditions](#)

[Medical Treatment](#)

[Doctors and Hospitals](#)

[Tests](#)

[Medicines](#)

[Other Medical Information](#)

Medicine Details

Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:

Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Other Medical Information

Other Medical Information for [REDACTED]

We need to know if anyone else has medical information about any of your conditions or if you are scheduled to see anyone else.

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid your disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else?

Yes No

Status	Medical Information Source	City	Phone	Actions
				<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- [Someone We Can Contact](#)
- [Medical Conditions](#)
- [Medical Treatment](#)
- [Doctors and Hospitals](#)
- [Tests](#)
- [Medicines](#)
- [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 [redacted]

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](#).

In this section...

Activities

[Work and Education](#)

[Vocational Rehabilitation](#)

[Next](#)

[Previous](#)

[Save & Exit](#)

Work and Education



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

- ✔ Identification
- ✔ Medical
- Activities/Training
- Review

Work and Education

Since you last told us about your work, have you worked or has your work changed?

Yes No

Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school, or college classes?

Yes No

What type of training?

Examples: carpentry, cosmetology, plumbing, electronics, data entry or word processing courses.

Date(s) attended:

Degrees(s) attained, if any:

Date of attainment:

-- --

Month

Year

If you need to enter more information, continue in [Remarks](#).

In this section...

✔ Activities

Work and Education

[Vocational Rehabilitation](#)

Next

Previous

Save & Exit

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

Medical Release Form

In order to make a decision about your disability claim, we need to obtain your:

- Medical Records
- Education Records
- Other information related to your ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration [SSA-827]) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Please read the [Medical Release Form](#) and make a selection below.

I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:

- Electronically sign** the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)
- Print, sign and mail a paper copy** of the Medical Release Form. I understand this may delay the processing of my disability claim.

[Next](#)

[Previous](#)

[Save & Exit](#)

In this section...

[Remarks](#)

Medical Release

[Summary](#)

3rd Party

About Applicant

Disability Appeal

Identification

Information about [redacted]

Name:

First Middle Last Suffix

Gender:
We only use this information to customize how we ask the questions for this appeal.
 Male Female

Mailing Address:
Country:

Street Address:
Street Line 1:
Street Line 2: [Add Line](#)
City/Town: **State/Territory:** **ZIP Code:**

Does [redacted] **live at the above address?**
 Yes No

Daytime Phone Number:
 U.S. International

10-digit Number Ext

Alternative Phone Number, if any:
Please provide another phone number where we can reach
 U.S. International

10-digit Number Ext

Email Address for [redacted]

Confirm Email Address:

[Next](#) [Previous](#) [Save & Exit](#)

In this section...
 Re-entry Number
 Preparer
Applicant Information

Appointed Rep



Social Security

The Official Website of the U.S. Social Security Administration

Disability Appeal

⚠ Identification **Medical** Activities/Training Review ⚠ Submit

Representative for [Redacted]

Does [Redacted] currently have an appointed representative? [More Info](#)

Yes No

Next Previous Save & Exit

In this section...

- ✓ Re-entry Number
- ✓ Preparer
- ✓ Applicant Information
- Representative**
- Appeal Request

Request for Hearing

OMB No. 0960-0269
Paperwork Reduction Act

Disability Appeal

⚠ Identification **Medical** Activities/Training Review ⚠ Submit

Request for Hearing by Administrative Law Judge for [Redacted]

What is the date on the "Notice of Decision" [Redacted] received? [Where to find this date](#)

mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

[Redacted] requests a hearing before an Administrative Law Judge. He disagrees with the determination made on his claim because: [What details to include](#)

Enter a brief reason for his appeal. (200 characters maximum)

Characters remaining: 200

Does [Redacted] wish to appear at a hearing? [More info about appearing](#)

[Redacted] wishes to appear at a hearing

[Redacted] does not wish to appear at a hearing and requests that a decision be made based on the evidence in his case. [\(Complete Waiver Form HA-4808\)](#)

Next Previous Save & Exit


In this section...

- ✓ Re-entry Number
- ✓ Preparer
- ✓ Applicant Information
- ✓ Representative
- Appeal Request**

Request for Reconsideration

Request for Reconsideration for [redacted]

What is the date on the "Notice of Decision" [redacted] received? [Where to find this date](#)


mm/dd/yyyy

Claim Number, if different from SSN: [Where to find the claim number](#)

[redacted] disagrees with the determination made on his claim and requests reconsideration because: [What details to include](#)

Enter a brief reason for his appeal. (200 characters maximum)

Characters remaining: 200

[Next](#) [Previous](#) [Save & Exit](#)

In this section...

- ✓ Re-entry Number
- ✓ Preparer
- ✓ Applicant Information
- ✓ Representative
- Appeal Request

Contacts

Disability Appeal

OMB No. 0960-0144
Paperwork Reduction Act

[Identification](#) [Medical](#) [Activities/Training](#) [Review](#) [Submit](#)

Someone We Can Contact about [redacted] Medical Conditions

Please give us the name of someone (other than doctors) we can contact who knows about medical conditions and can help him with this appeal.

Who can help us with this appeal?

Someone Else

No one

[Next](#) [Previous](#) [Save & Exit](#)

In this section...

- Someone We Can Contact
- Medical Conditions
- Medical Treatment
- Doctors and Hospitals
- Tests
- Medicines
- Other Medical Information

Medical Conditions

Identification Medical Activities/Training Review Submit

Change in Conditions for .

Since . : last told us about his medical conditions, has there been any CHANGE (for better or worse) in his previously described physical or mental conditions? [What are changes in conditions?](#)

Yes No

Date the change(s) occurred:

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

Please describe the change(s) to . condition(s) in detail:
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in [Remarks](#).

In this section...

Someone We Can Contact

Medical Conditions

Medical Treatment

Doctors and Hospitals

Tests

Medicines

Other Medical Information

New Conditions

Since . : last told us about his medical conditions, does he 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 . ; 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

Disability Appeal

Identification

Medical

Activities/Training

Review

 Submit

Other Names for

Has used any other names on his medical or educational records?

For example, maiden name, other married name, or nickname.

Yes No

Other Name 1:

First

Middle

Last

Suffix

[Add Another Name](#)

In this section...

[Someone We Can Contact](#)

[Medical Conditions](#)

Medical Treatment

[Doctors and Hospitals](#)

[Tests](#)

[Medicines](#)

[Other Medical Information](#)

Medical Treatment

Since last told us about his medical treatment, has he seen a doctor or other healthcare provider, received treatment at a hospital or clinic, or does he have a future appointment scheduled?

Yes No

What type(s) of condition(s) was treated for, or will he be seen for?

Physical Mental (including emotional or learning problems)

[Next](#)

[Previous](#)

[Save & Exit](#)

Doctors and Hospitals

Doctors and Hospitals for

Please tell us about anyone who has **new or updated** medical records about any of his physical or mental conditions (including emotional or learning problems).

Status	Doctor or Healthcare Provider	City	Actions
<input type="checkbox"/>			<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Status	Hospital or Clinic	City	Actions
<input type="checkbox"/>			<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

[Someone We Can Contact](#)

[Medical Conditions](#)

[Medical Treatment](#)

[Doctors and Hospitals](#)

[Tests](#)

[Medicines](#)

[Other Medical Information](#)

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) 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 _____ 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) you 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 [redacted] 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 [redacted] most recent emergency room visits.

Emergency Room Visit 1:

Emergency Room Visit 2:

Emergency Room Visit 3:

Did [redacted] 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

Disability Appeal

✓ Identification

Medical

Activities/Training

Review

⚠ Submit

Tests for [redacted]

Since you last told us about your disability, please tell us about any medical tests [redacted] : had or will have related to his disability.

Status	Name of Test	Test Ordered by	Actions
	[redacted]	[redacted]	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

✓ Someone We Can Contact

✓ Medical Conditions

✓ Medical Treatment

✓ Doctors and Hospitals

✓ Tests

Medicines

Other Medical Information

Test Details

Disability Appeal

Test Details

Test Type:

Date(s) of Test:

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

Who ordered this test for [redacted] ?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Medicines/Medical

✓ Identification Medical Activities/Training Review ⚠ Submit

Medicines for

Please tell us about **ALL prescription and non-prescription medicines** that is currently taking for the conditions related to his disability.

Status	Name of Medicine	Prescribed by	Actions
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

- ✓ [Someone We Can Contact](#)
- ✓ [Medical Conditions](#)
- ✓ [Medical Treatment](#)
- ✓ [Doctors and Hospitals](#)
- ✓ [Tests](#)
- ✓ **Medicines**
- [Other Medical Information](#)

Medicine details

Medicine Details

Enter name of the medicine:

Enter only one medicine at a time. Look at the medicine container if necessary.

Why is _____ taking this medicine?

Describe any side effects _____ experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Characters remaining: 1000

Who recommended or prescribed this medicine?

If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Save

Cancel

Other Medical Information

Other Medical Information for [REDACTED]

We need to know if anyone else has medical information about any of [REDACTED] conditions or if he is scheduled to see anyone else.

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid [REDACTED] disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

Since [REDACTED] last told us about his other medical information, does anyone have medical information about any of his physical or mental conditions (including emotional and learning problems) or is he scheduled to see anyone else?

Yes No

Status	Medical Information Source	City	Phone	Actions
()				<input type="button" value="Edit"/> <input type="button" value="Delete"/>

In this section...

[Someone We Can Contact](#)

[Medical Conditions](#)

[Medical Treatment](#)

[Doctors and Hospitals](#)

[Tests](#)

[Medicines](#)

[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: 8/2/2015; 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 [redacted]

Since [redacted] 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



Social Security

Official Website of the U.S. Social Security Administration

Disability Appeal

- Identification
- Medical
- Activities/Training**
- Review

Work and Education for [redacted]

Since [redacted] last told us about her work, has she worked or has her work changed?
 Yes No

Since [redacted] last told us about her education, has she completed or has she enrolled in any type of GED classes, specialized job training, trade school, vocational school, or college classes?
 Yes No

What type of training?
Examples: carpentry, cosmetology, plumbing, electronics, data entry or word processing courses.

Date(s) attended:

Degrees(s) attained, if any: **Date of attainment:**
Month Year

If you need to enter more information, continue in [Remarks](#).

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

- Next**
- Previous
- Save & Exit

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

In this section...
Remarks
Medical Release
Summary

[Next](#)

[Previous](#)

[Save & Exit](#)

Medical Release

Disability Appeal

- ✔ Identification
- ✔ Medical
- ✔ Activities/Training
- Review
- ⚠ Submit

Medical Release Form for [REDACTED]

In order to make a decision about this disability claim, we need to obtain [REDACTED] information:

- Medical Records
- Education Records
- Other information related to his ability to perform tasks

We will help get required records with permission. Signing the Medical Release Form (Authorization to Disclose Information to the Social Security Administration [SSA-827]) is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on the claim, and could result in denial or loss of benefits.

Is [REDACTED] with you and can he read Medical Release Form now?

Yes No

Please ask [REDACTED] to read the [Medical Release Form](#) and make a selection below.

I voluntarily authorize and request disclosure of all my medical records; also educational records and other information related to my ability to perform tasks. I agree to:

- Electronically sign** the Medical Release. My electronic signature is the same as my handwritten signature. (Recommended)
- Print, sign and mail a paper copy** of the Medical Release Form. I understand this may delay the processing of my disability claim.

In this section...

✔ [Remarks](#)

Medical Release

[Summary](#)

[Next](#)

[Previous](#)

[Save & Exit](#)