SOCIAL SECURITY ADMINISTRATION

Refer To:
[ClaimantFirstName][ClaimantLastName]
[ClaimantDOB]

Office of Hearings Operations
Hearing Office Name
Hearing Office Address
Tel: (xxx)xxx-xxxx / Fax: (xxx)xxx-xxxx

[Today's Date]

[Doctor Name]
[Doctor Address]

A claim for disability benefits, filed by the above-named individual under the Social Security Act, is before the Office of Hearings Operations 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,

Form HA-L66 (03-2007)

See Next Page

[SigneeName]
[SigneeTitle]

Enclosures

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

<if Rep>
[RepFirstName][RepLastName]
<ifRepFirm>[RepFirm] <endif>
[RepFirmAddress]
<endif>

Form HA-L66 (03-2007)

See Next Page

[Doctor Name]
[Doctor 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.

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;

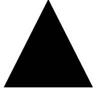
2. To comply with Federal laws requiring the release of information from Social Security records to other agencies (e.g., to the Government Accountability Office, and the Department of Veterans Affairs);

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

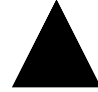
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

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 each set of documents returned.

Fax the evidence to this fax number:

[Scanner Phone number]

RQID:000000000000000000555514 SITE:T24 DR:S
SSN:006502602 DOCTYPE:0001 RF:D CS:41ff

Sample Barcode above

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