

# PROPOSED

FORM APPROVED OMB No. 3220-0039



UNITED STATES OF AMERICA  
**RAILROAD RETIREMENT BOARD**  
OFFICE OF PROGRAMS - OPERATIONS  
POST OFFICE BOX 10695  
CHICAGO, ILLINOIS 60610-0695

OFFICE HOURS: M-T-TH-F 9:00 AM TO 3:30 PM  
WEDS. 9:00 AM TO 12:00 PM - CLOSED FEDERAL HOLIDAYS

TOLL-FREE NUMBER: 1-877-772-5772

### VERIFICATION OF MEDICAL INFORMATION

The purpose of this notice is to verify the accuracy of the enclosed photocopy of a medical report received from your office. Please examine the report to check for errors or falsifications by the patient. Reply **ONLY** if:

1. the subject of the report is not your patient;
2. your office did not complete the report; or
3. the report was not accurate when made.

If the report is incorrect, please show corrections or further information below and sign and mail this form to the address shown above.

**DO NOT REPLY IF THE REPORT IS CORRECT.**

Thank you for your cooperation.

U. S. Railroad Retirement Board

READ IMPORTANT NOTICES ON THE NEXT PAGE

PATIENT:

SS NO.:

Do **not** complete or return this form if the enclosed report is **correct**. If the report is erroneous, please check all applicable boxes and provide any relevant information.

- |  |  |
|--|--|
| <input type="checkbox"/> The subject is <b>not</b> my patient.   | <input type="checkbox"/> My office did <b>not</b> complete the report. |
| <input type="checkbox"/> The subject was <b>not</b> my patient at the time the medical report was completed. | <input type="checkbox"/> The report was <b>not</b> accurate when made. |

REMARKS:

\_\_\_\_\_  
NAME OF PROVIDER

\_\_\_\_\_  
SIGNATURE OF PROVIDER

\_\_\_\_\_  
DEGREE/TITLE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
\_( )\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NATIONAL PROVIDER IDENTIFIER

### **Paperwork Reduction Act Notice to Health Care Provider**

If information is furnished, it is to be furnished without expense to the Railroad Retirement Board (RRB). If applicable, please complete the items on the reverse side. The RRB is authorized to collect this information under section 12(i) of the Railroad Unemployment Insurance Act. You are not required under law to provide any of the information requested on the reverse side of this form. However, if for any reason you do not provide relevant information, benefits may be improperly paid to this patient or denied by the RRB.

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We estimate this form takes an average of 5 minutes to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to Associate Chief Information Officer for Policy & Compliance, Railroad Retirement Board, 844 Rush St., Chicago, Illinois 60611-1275.