PRIMARY CARE
123 MAIN STREET
ANYTOWN DE 22222

DEMO
ENVIRONMENT

This correspondence was formatted for mailing in an envelope with the pages folded once.

CONFIDENTIALITY NOTICE: The accompanying material contains sensitive information. This information may be privileged and confidential, and intended for the use of the recipient named in this correspondence. If you have received this information in error, please contact us immediately.

DDS 4
4496 NORTH MARKET ST

SUITE 300
PHILADELPHIA, KS 19807-1000
TEL: (555) 555-5555 Fax: (987) 654-3210

RQID:DCM13045 SITE:S09 DR:S
SSN:********* DOCTYPE:0001 RF:D CS:530e

CLAIMANT: DCPS Danielle Brown
CASE NUMBER: 1401
REQUEST ID: DCM13045
Fiscal ID: 37
June 27, 2022

PROVIDER:
Primary Care
123 Main Street
Anytown, DE 22222
Tax ID #: N/A
Phone: N/A

PAYEE:
Primary Care
123 Main Street
Anytown, DE 22222

TO ENSURE PROPER PAYMENT, PLEASE VERIFY PAYEE AND TAX ID INFORMATION LISTED ABOVE AND THEN SIGN BELOW

Records can be Faxed to: (123) 456-7945

If you are sending by Fax, place this page ON TOP of medical evidence.
If you are also sending your own invoice, place your invoice directly behind this invoice.

When submitting your records using the **Electronic Records Express (ERE),** use the following: http://eme.ssa.gov. This method of submission requires an ERE account, ID, and password. Additional information on ERE is available at **www.ssa.gov/ere**.

TOTAL MAXIMUM CHARGE	SERVICE	TOTAL CHARGE
[$15.00]	Medical Evidence of Record	$__________

I certify that the above service has been provided. Service provided under this authorization is to be furnished without discrimination with regard to race, color, or national origin.

X____________________________ ____________
SIGNATURE BY OR FOR PAYEE DATE

Confidentiality Notice: This message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. If you are not the intended recipient, or an authorized agent of the intended recipient, please immediately contact the sender at the phone number above and destroy all copies of the original message. Any unauthorized review, use, copying, disclosure, or distribution by other than the intended recipient or authorized agent is prohibited.

THIS IS AN INVOICE - PLEASE RETURN FOR PAYMENT.
***** INVOICE IS VOID AFTER 90 DAYS *****

FOR OFFICE USE ONLY

(Stephanie Schmidt)

FOR FISCAL DEPARTMENT USE ONLY
PAID DATE:____________________
VOUCHER ID:___________________

AUTHORIZED SIGNATURE ______________________

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DISABILITY DETERMINATIONS SERVICE
SSA
S09 Delaware DDS
SUITE 300
NEW CASTLE, DE 19720-1000
TEL: (555) 555-5555

PRIMARY CARE
123 MAIN STREET
ANYTOWN DE 22222

Date: June 27, 2022
Case ID: 1401

RE: DCPS Danielle Brown
AKA: Jacob Johnny Zimmermann Jr
Shahrukh Khan
DOB: February 17, 1975
Vendor Number: 100008

We are the office that makes disability decisions for the Social Security Administration.
DCPS Danielle Brown is applying for or is receiving disability benefits due to the following conditions: Heart condition. This is not an authorization to perform an examination.

What We Need From You

To help us evaluate this claim, please send records covering the period of: 09/30/2019 to present.

Include the following information: medical history, psychiatric history, clinical findings, laboratory findings, imaging reports, treatment prescribed and the response, diagnosis, and prognosis.

Please respond by July 11, 2022. We are enclosing a signed HIPAA compliant authorization for the release of medical records and information.

Please provide a statement based on your findings. Your statement should express your opinion about your patient's ability to do work-related physical and/or mental activities despite the limitations or restrictions imposed by her medical condition(s). For physical impairments, these activities include sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical activities (including manipulative or postural activities, such as reaching, handling, stooping, or crouching); other activities, such as seeing, hearing, or using other senses; and ability to adapt to environmental conditions, such as temperature extremes or fumes. For mental impairments, these activities include understanding; remembering; maintaining concentration, persistence, or pace; carrying out instructions; and responding appropriately to supervision, coworkers, and work pressures.

If you would like payment for your records, please (1) submit and sign the invoice, (2) complete and submit a W-9 forms online per attached "Substitute Form W-9 Request" instructions and (3) submit copies of your records. This will allow prompt payment for records you submit to Disability Determination Services. The information from the W-9 form will allow us to add you to our payment system, which will expedite future payments for records.

If it is determined that we need additional information regarding your patient's impairments, would you be willing to perform an examination to provide additional findings? Please contact us if you would be willing to perform this examination. We will assume that you do not wish to perform the examination if you do not respond.

If You Have Any Questions

If you have any questions or wish to provide more information, please call us at the number(s) shown below Monday - Friday between 11:30 am and 7:30 pm. When you call or leave a message, please provide the Case ID: 1401, your name, DCPS Danielle Brown's name, and a call back number.

Thank you for your help.

DEMO ENVIRONMENT

S. Schmidt
(301) 555-1212
(987) 654-3210 (FAX)

Enclosure(s):
Invoice
Cardiac Questionnaire
Privacy Act and Paper Reduction Act Statement
SSA-827 (Authorization to Disclose Information to the Social Security Administration (SSA))
Return Envelope

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State of Delaware

Substitute Form W-9 Request

The State of Delaware's Division of Accounting **requires** that a Substitute W-9 form be completed **online**. This process is *mandatory* for all vendors (payees) before any payments can be made.

Please go to this website: www.accounting.delaware.gov and select the link "W9 Form" at the bottom of the webpage.

Please complete and print a copy using your internet's Print option or "Ctrl+P" while on the webpage. Once printed, select "Submit". Expect a call from our Vendor Maintenance Team to verify your information.

For questions regarding the vendor forms, please call (302) 672-5000 and ask to speak with a member of the vendor team.

PLEASE NOTE:

- *No paper forms* will be accepted in lieu of the online process. We are asking for a Substitute W9, not the Standard IRS Form W9.
- Please ensure that the Tax ID/EIN is correct on our document as well as any other information. You may indicate corrections on the Authorization for payment invoice.
- Please sign the Authorization and return all documents to the DE DDS.

Thank You

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Form Approved
OMB No. 0960-0555

Date: June 27, 2022
Case ID: 1401
Claimant Name: DCPS Danielle Brown

PLEASE COMPLETE AND RETURN BY JULY 11, 2022

CARDIAC QUESTIONNAIRE

1) Diagnosis: ______________________ Date of diagnosis: ______________

2) Date and findings of your most recent exam: ______________________

____

3) Would undergoing exercise testing pose significant risk to your patient? ☐ Yes ☐ No

4) If the patient has chest pain, is it related to a cardiac condition? ☐ Yes ☐ No

If no, what non-cardiac condition is causing chest pain? ______________________

5) Has the patient experienced cyanosis at rest? ☐ Yes ☐ No On exertion? ☐ Yes ☐ No

6) Describe the patient's cardiac signs and symptoms (for example, dyspnea, fatigue, palpitations, chest discomfort, edema, varicosities, stasis dermatitis, ulcerations, claudication).

____

____

7) Describe the location, duration, and frequency of the patient's symptoms. ______________

____

8) Describe any precipitating factors (for example, physical activity, eating, cold air). ______________

____

9) What relieves the patient's symtoms (for example, rest, position, medication)? ______________

____

10) Are the symptoms acute or chronic? ______________________

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11) Current New York Heart Association class rating: _________. Based on this rating describe the patient's physical limitations (for example, difficulty with household tasks, walking, stairs, lifting).

12) Describe any evidence of neurological complications (for example, ataxia, paralysis, aphasia).

13) Is there evidence of end-organ damage as a result of hypertension (for example, kidney failure, retinopathy)? ☐ Yes ☐ No

If yes, describe.

Treatment:

MEDICATION	DOSAGE AND FREQUENCY

PAST TREATMENT OR RECOMMENDATION(S) (FOR EXAMPLE, ANGIOPLASTY, CABG, PACEMAKER)	DATE PERFORMED OR SCHEDULED

14) Have the symptoms persisted despite treatment?

15) Describe any restrictions to work-related activities, if not previously provided (for example, walking, lifting, carrying).

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NOTE: Please submit copies of any testing and laboratory results, if you have not provided them previously.

Physician's Signature | Date | Phone NUmber

Printed Name | Title

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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.*

DEMO ENVIRONMENT

Form Approved
OMB No. 0960-0623

WHOSE ***Records to be Disclosed***

NAME *(First, Middle, Last, Suffix)*	
Gary Martin Ashcraft	
SSN 508-01-1205	Birthday *(mm/dd/yy)* 10/23/71

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange)**:**

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including*****, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM
- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

Primary Care
123 Main Street
Anytown, DE 22222
09/30/2019 to present

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services")**, including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

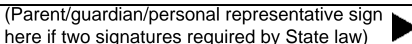
- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN
Electronically Signed By:
Gary Martin Ashcraft

IF not signed by subject of disclosure, specify basis for authority to sign
☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) 

Date Signed	Street Address		
07/24/19	C/O UNION GOSPEL MISS 3211 IRVING BLVD		
Phone Number (with area code)	**City**	**State**	**ZIP**
214-402-6901	DALLAS	TX	75247-6031

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN
Attested by SSA or Designated State Agency Employee:
T Foulke

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN

Phone Number (or Address)	Phone Number (or Address)
866-931-4958 DALLAS TX 75237-3867	

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827
"Authorization to Disclose information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d) (5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits

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, including but not limited to the following:

a) To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

b) To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);

c) To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

d) To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

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. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office

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