Social Security Administration

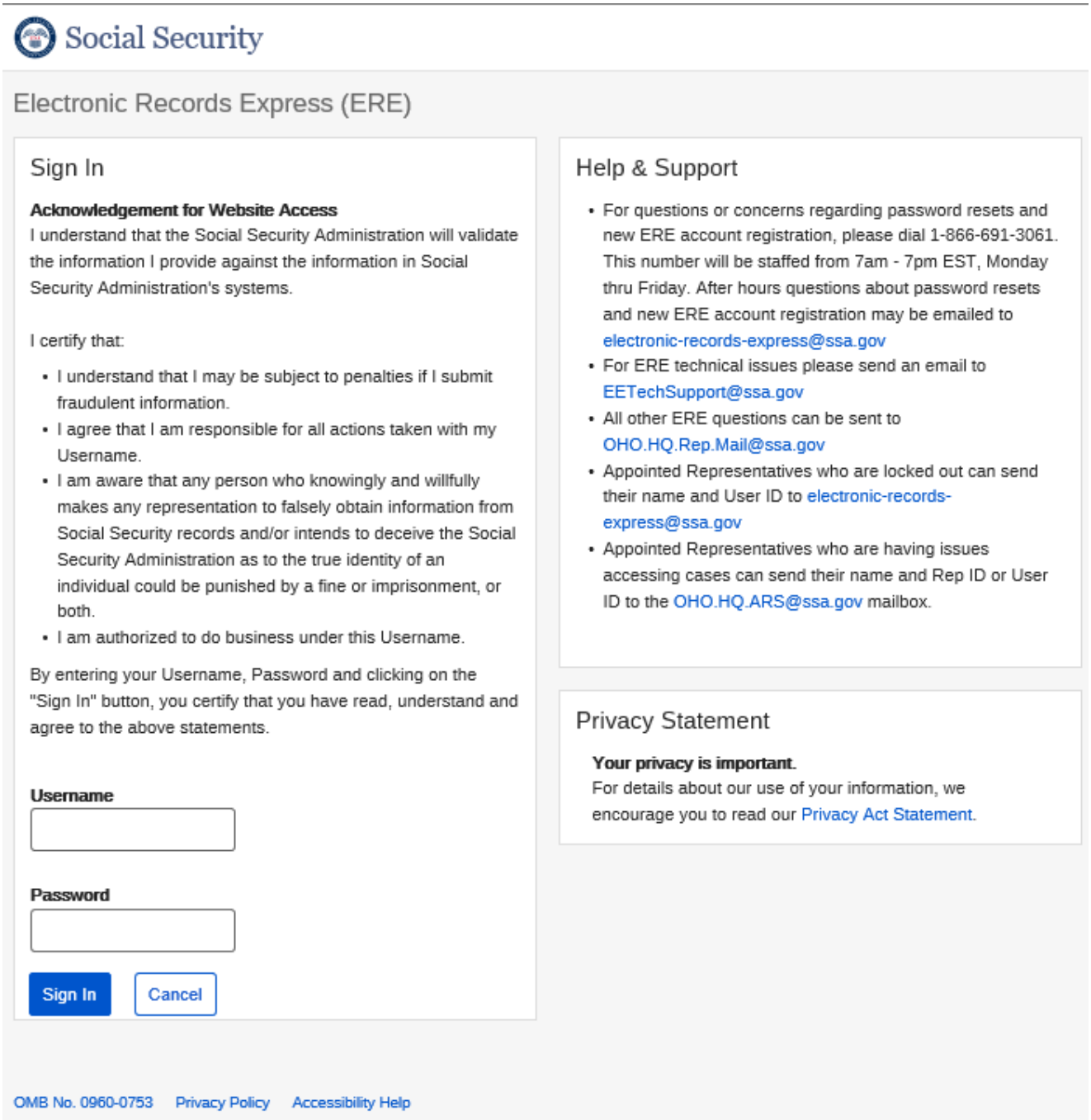
SEPTEMBER 2020 ERE Screen Shots

For OMB Clearance 0960-0753

Table of Contents

ERE Login

Login Screen



Private Act Statement

Social Security

Privacy Act Statement

Collection and Use of Personal Information

Section 205 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 offering you access to our Business Services Online (BSO) suite of services.

We will use the information that you provide to register you, your company, or authorized employee(s) to use our BSO suite of services. We will verify the personally identifiable information (e.g., name, Social Security number, and date of birth) you provide against our records for user registration. We may also share your information for the following purposes, called routine uses:

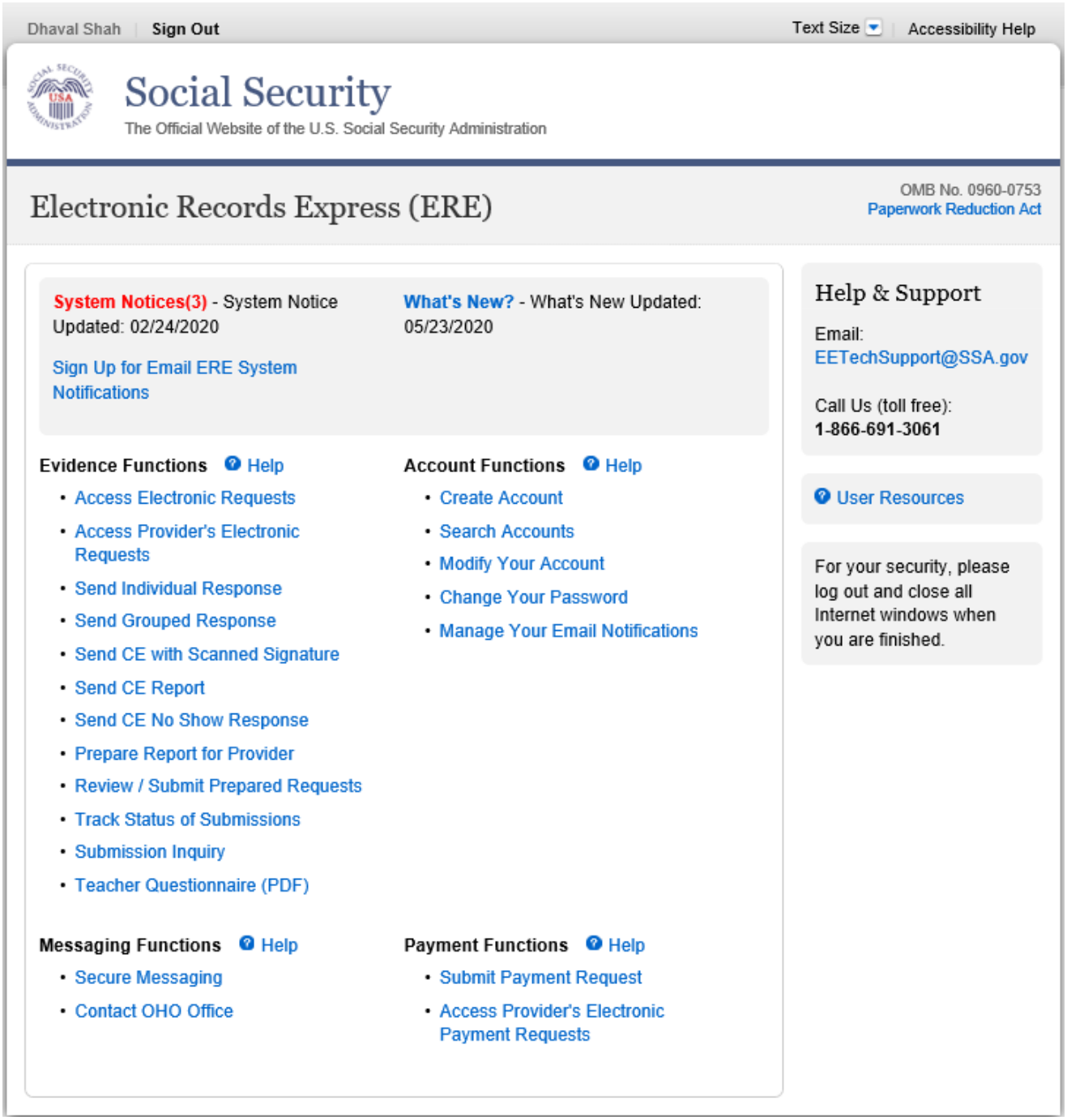
1. To a congressional office in response to an inquiry from that office made at the request of the subject of a record or a third party on that person's behalf.; and
2. To other Federal agencies and our contractors, including external data sources, to assist us in administering our programs.

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) 60-0058, entitled Master Files of Social Security Number (SSN) Holders and SSN Applications and 60-0373, entitled Central Repository of Electronic Authentication Data Master File. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

ERE Home Page

Administrator's Home Page View

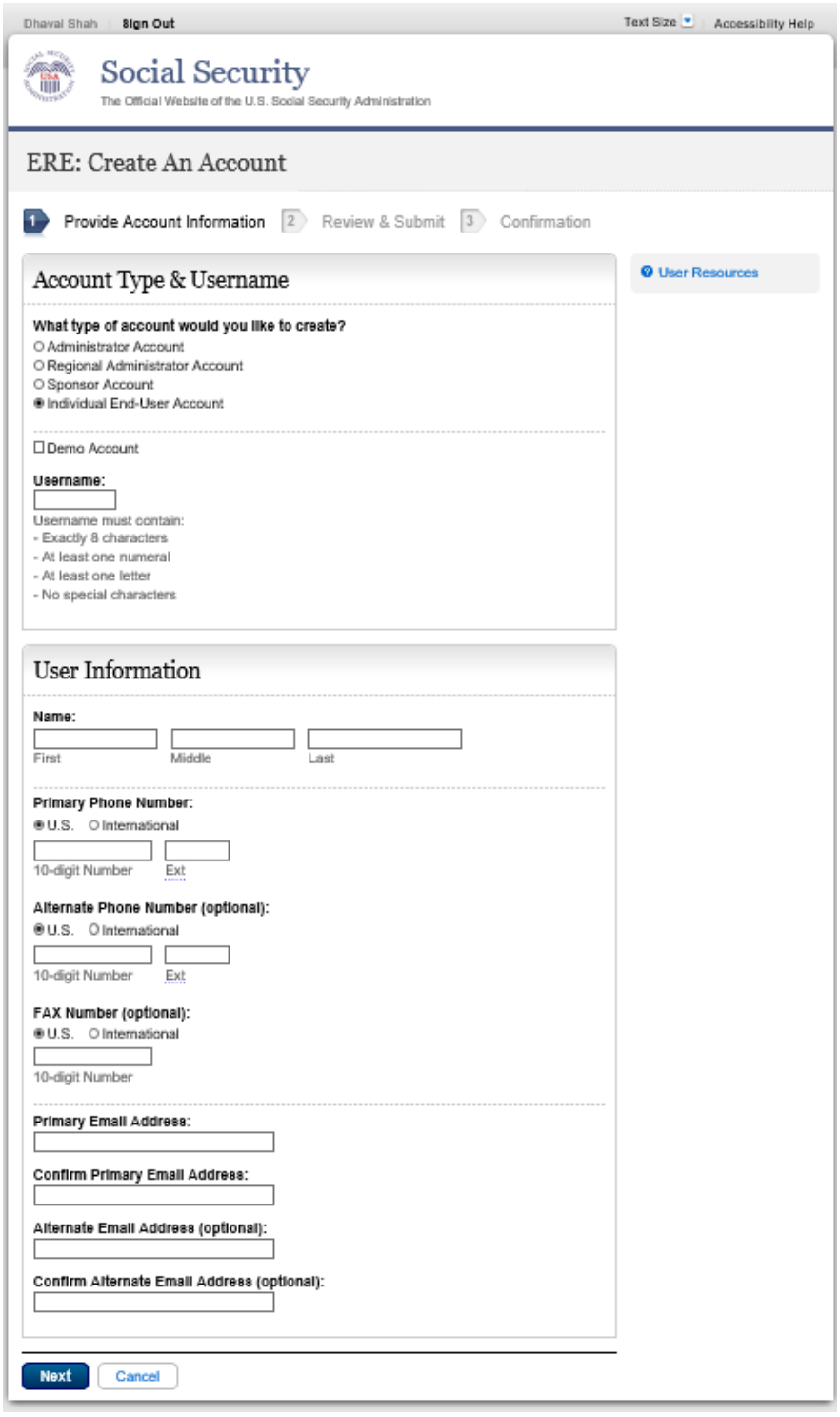


Individual End-User Home Page View

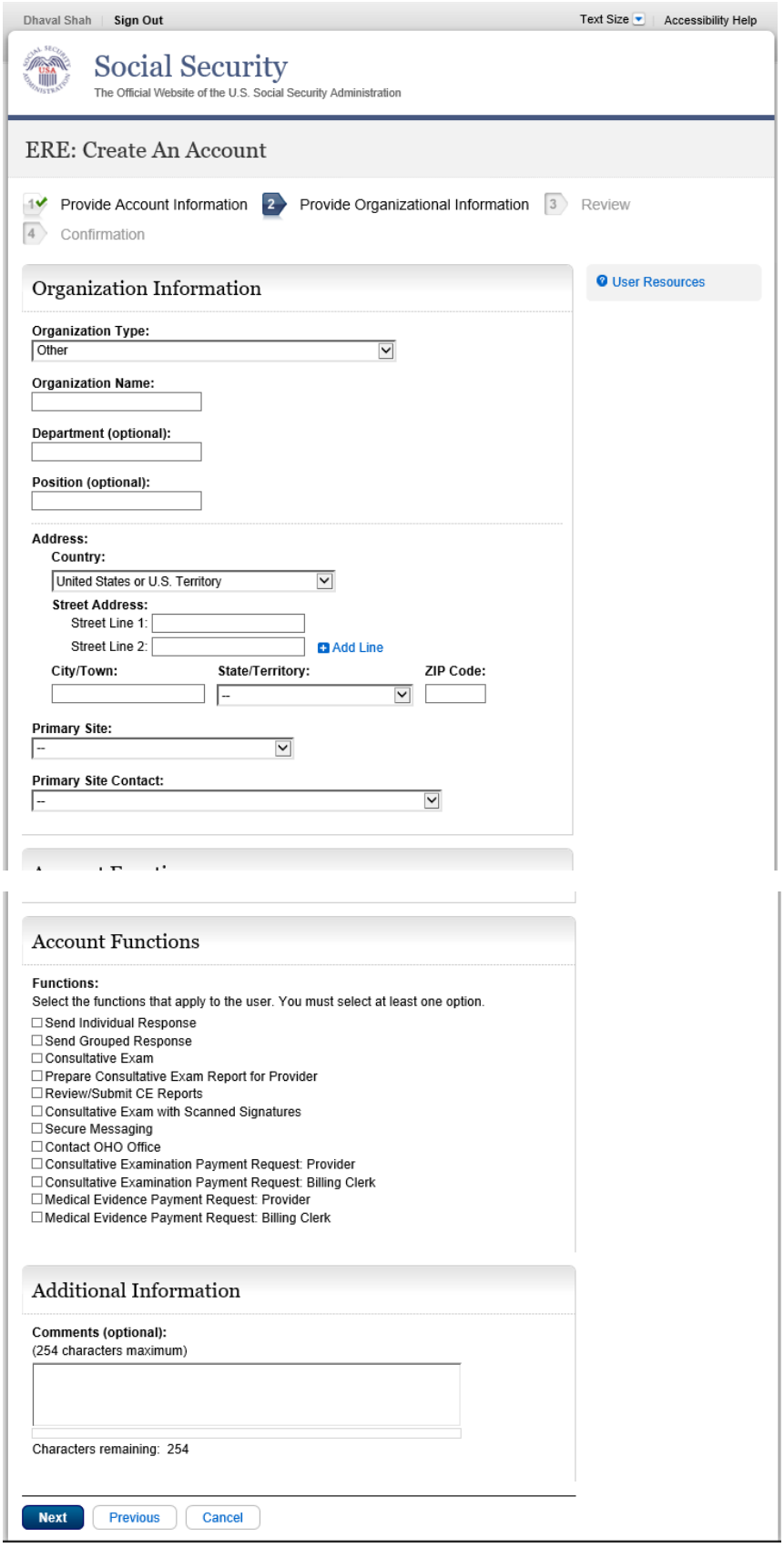
Account Services

Create an Individual End-User Account

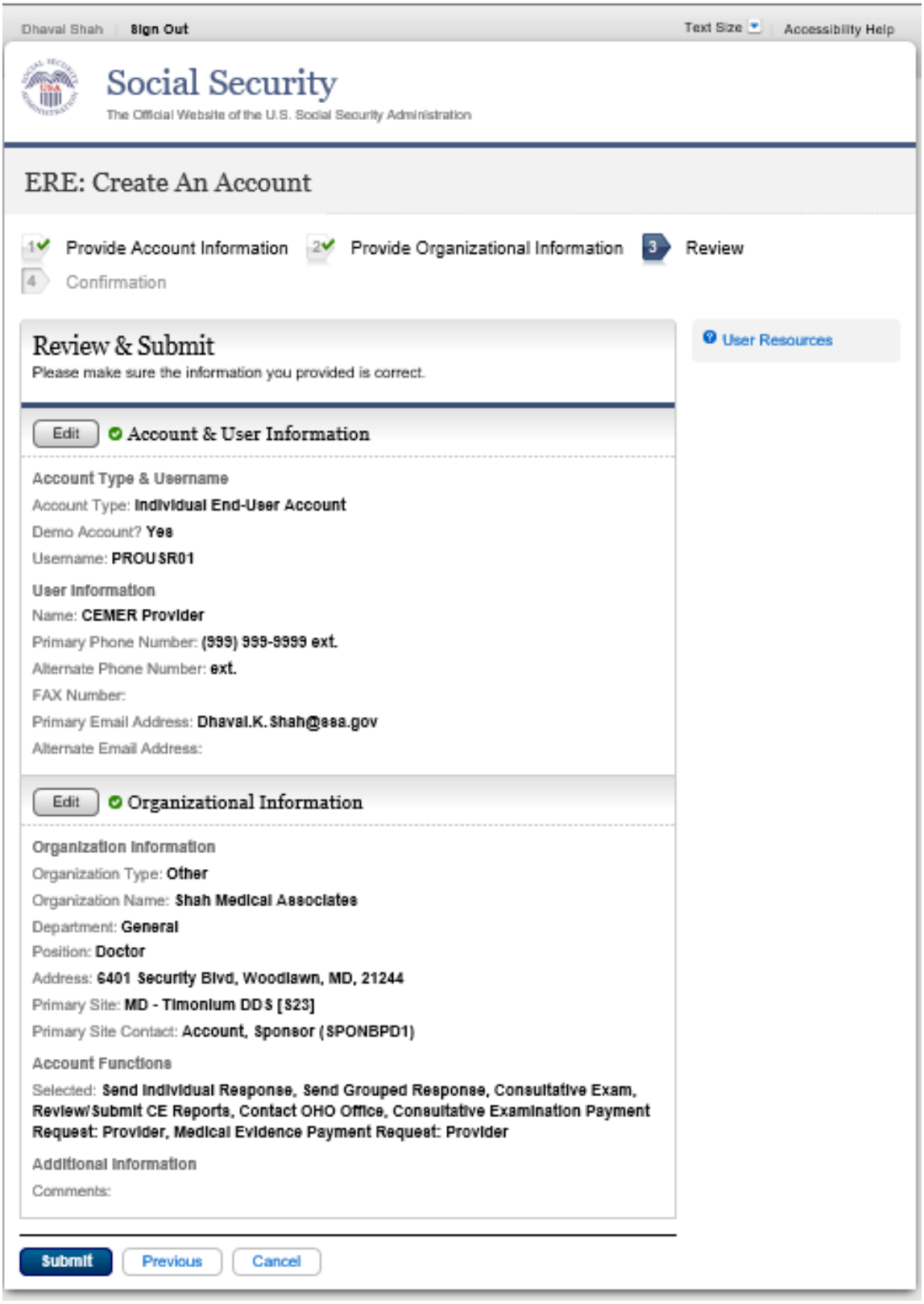
Basic Information



Organization Information

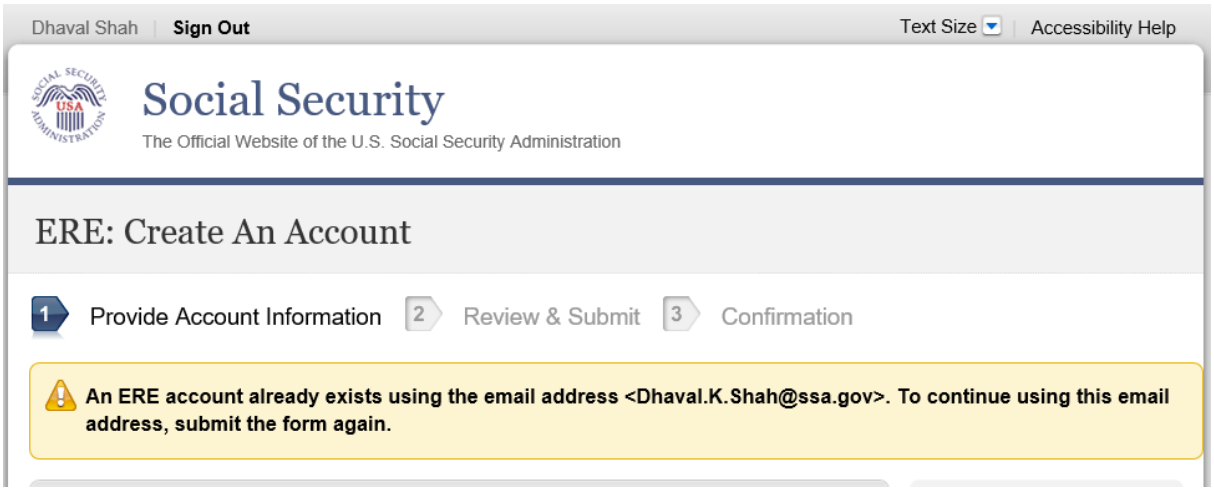


Review


Dhaval Shah | Sign Out
Text Size | Accessibility Help
Social Security
The Official Website of the U.S. Social Security Administration
ERE: Create An Account
1 Provide Account Information
2 Provide Organizational Information
3 Review
4 Confirmation
Review & Submit
Please make sure the information you provided is correct.
User Resources
Edit
Account & User Information
Account Type & Username
Account Type: Individual End-User Account
Demo Account? Yes
Username: PROUSR01
User Information
Name: CEMER Provider
Primary Phone Number: (999) 999-9999 ext.
Alternate Phone Number: ext.
FAX Number:
Primary Email Address: Dhaval.K.Shah@ssa.gov
Alternate Email Address:
Edit
Organizational Information
Organization Information
Organization Type: Other
Organization Name: Shah Medical Associates
Department: General
Position: Doctor
Address: 6401 Security Blvd, Woodlawn, MD, 21244
Primary Site: MD - Timonium DDS [S23]
Primary Site Contact: Account, Sponsor (SPONBPD1)
Account Functions
Selected: Send Individual Response, Send Grouped Response, Consultative Exam, Review/Submit CE Reports, Contact OHO Office, Consultative Examination Payment Request: Provider, Medical Evidence Payment Request: Provider
Additional Information
Comments:
Submit
Previous
Cancel

Confirmation

Duplicate e-Mail warning message for multiple ERE accounts

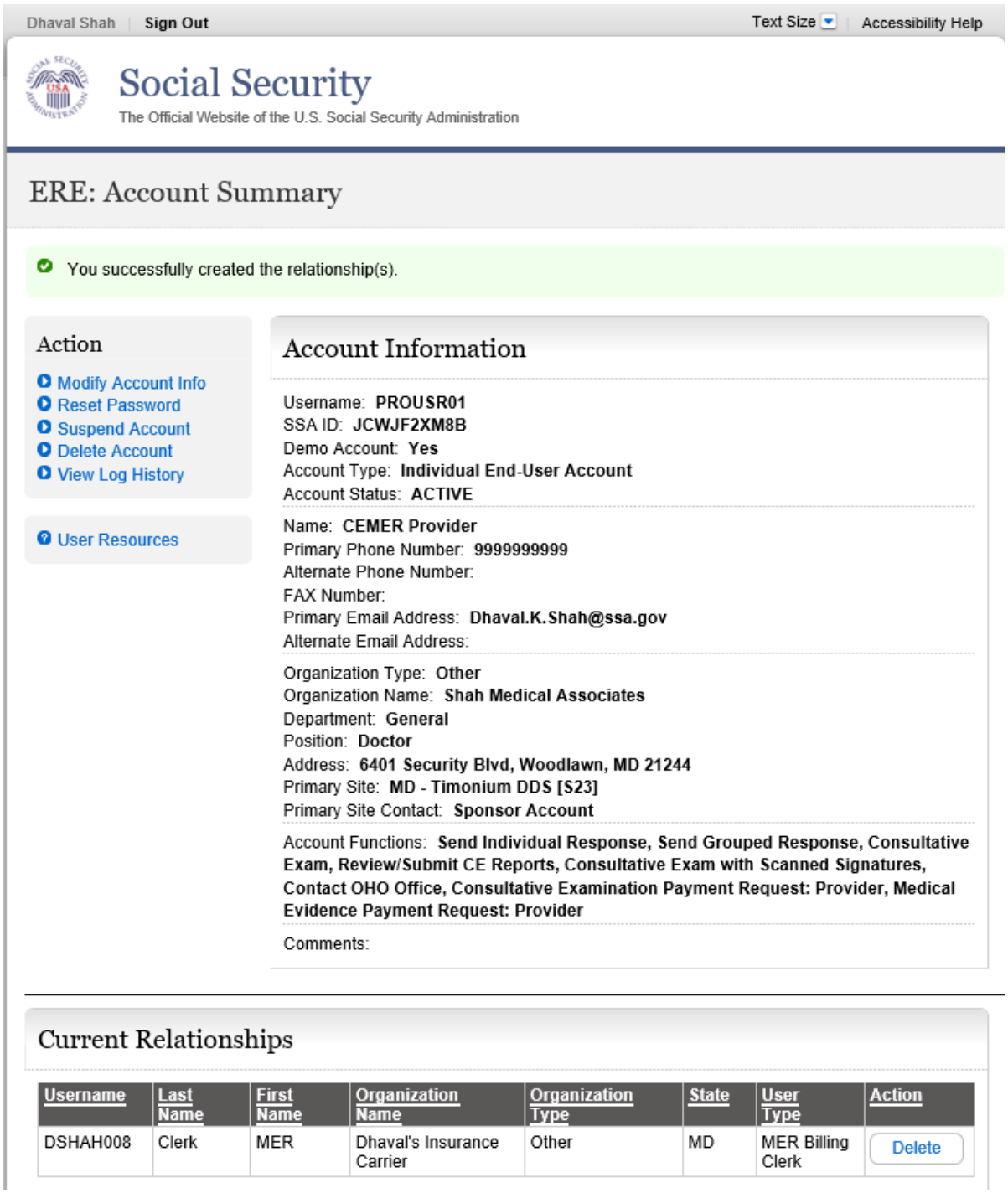


Manage End-User Relationships

Search Criteria

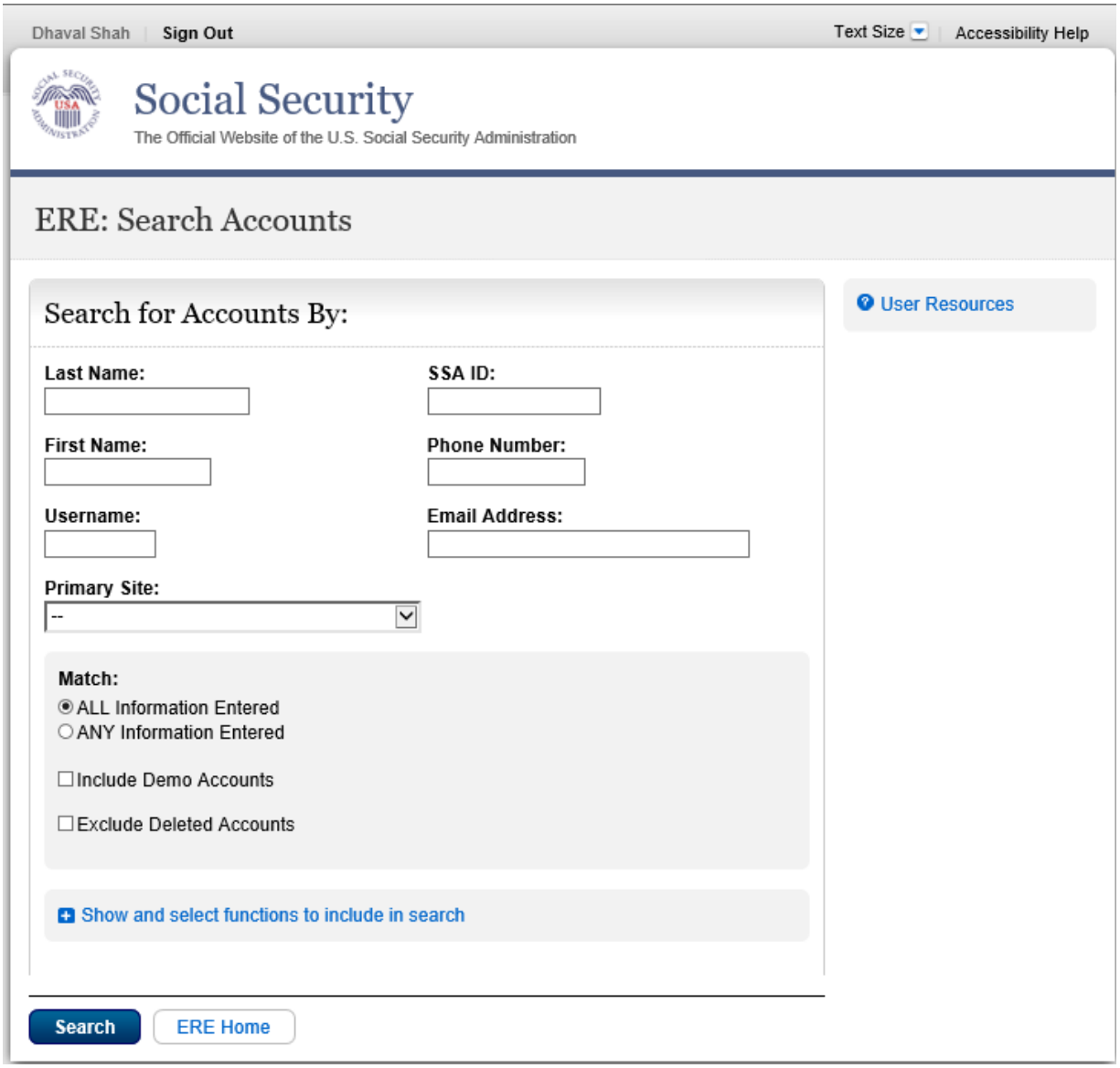
Search Results

Create Individual End-User Account Summary

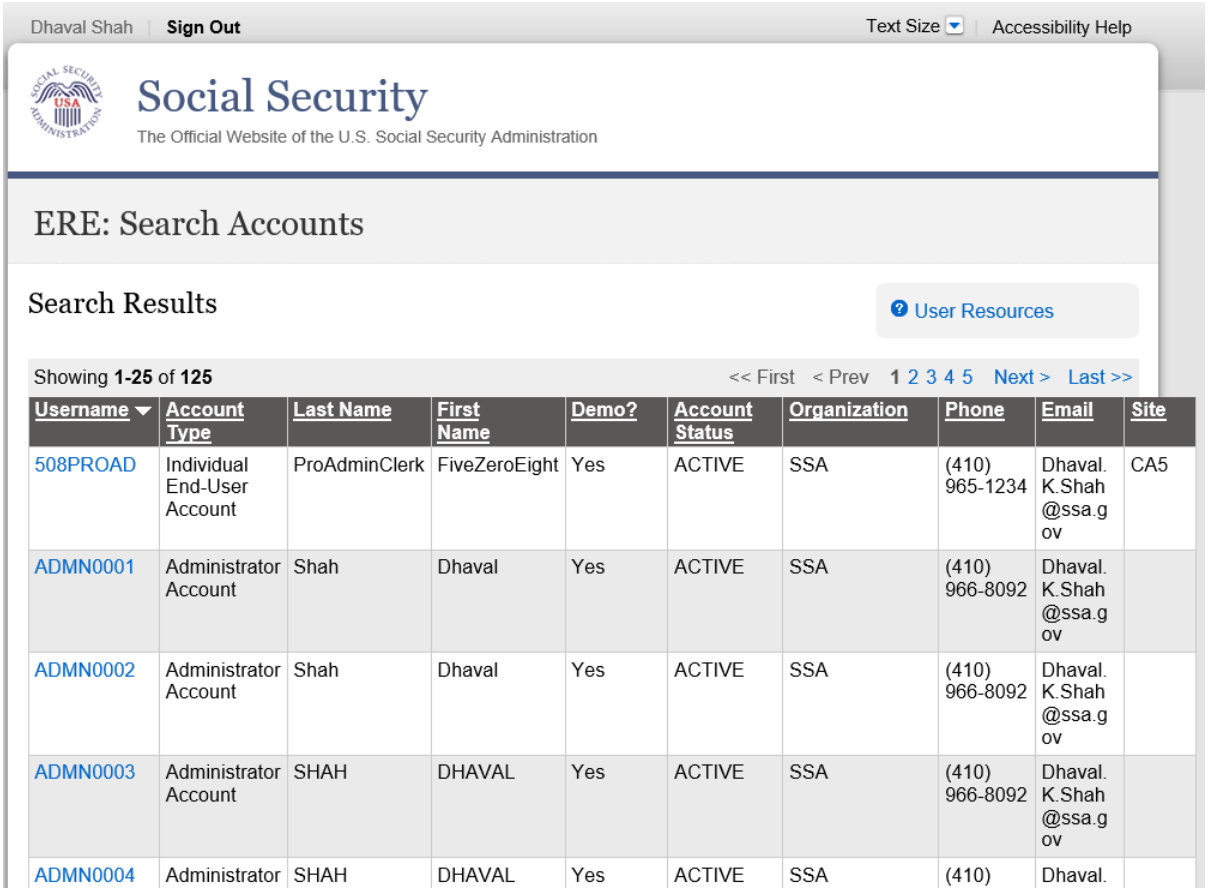


Search Accounts

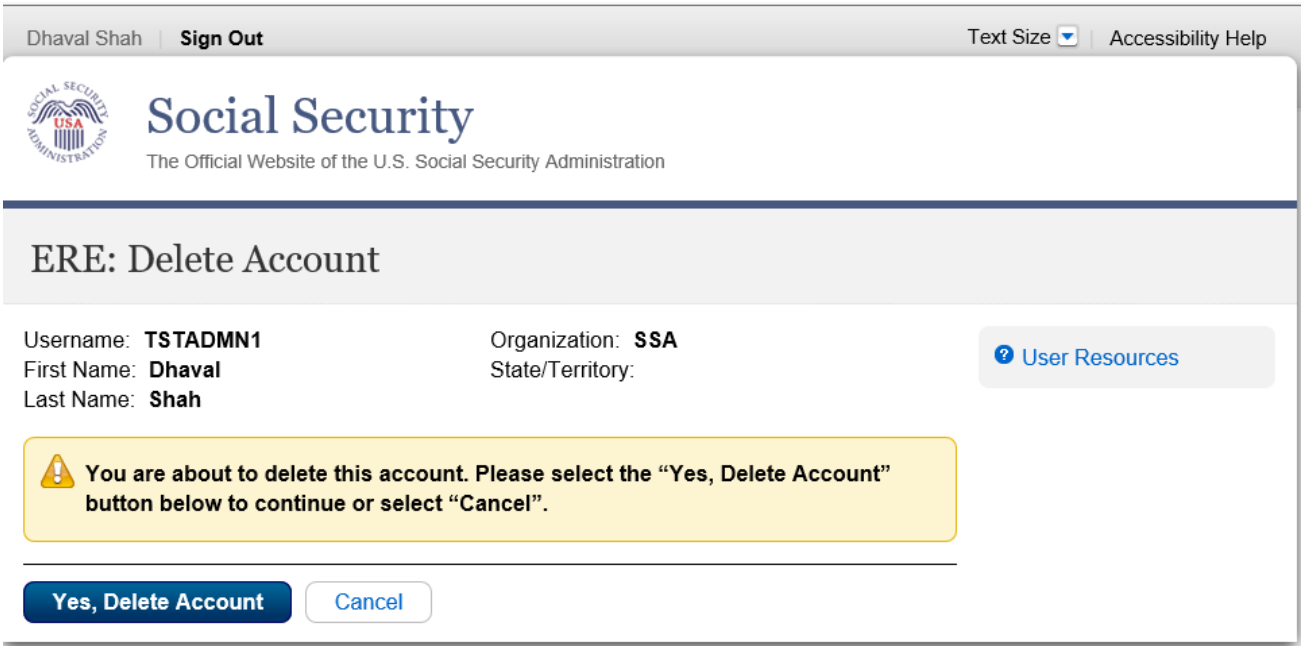
Search Page



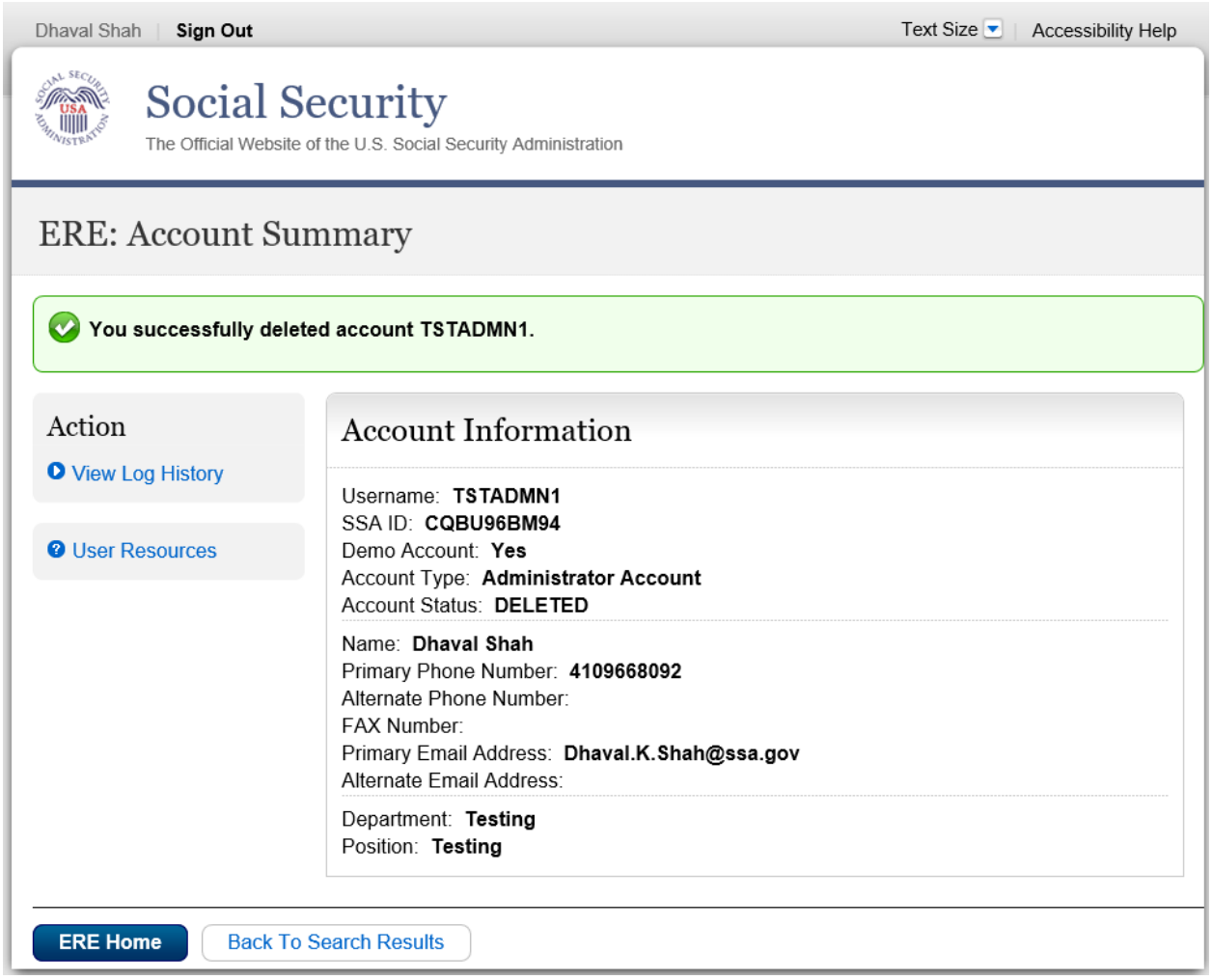
Search Results



Delete Account

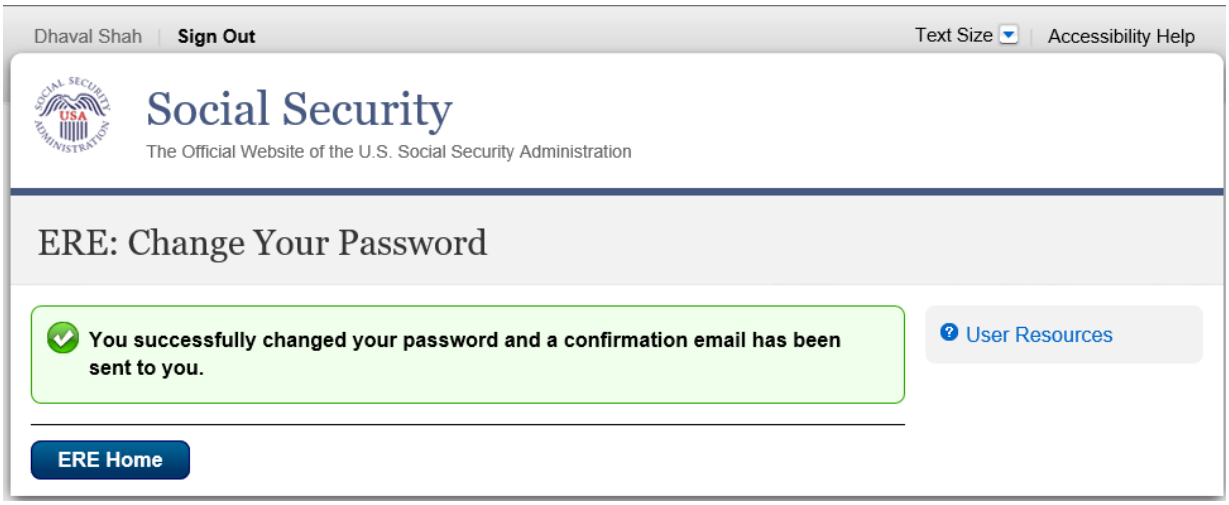


Delete Account Summary

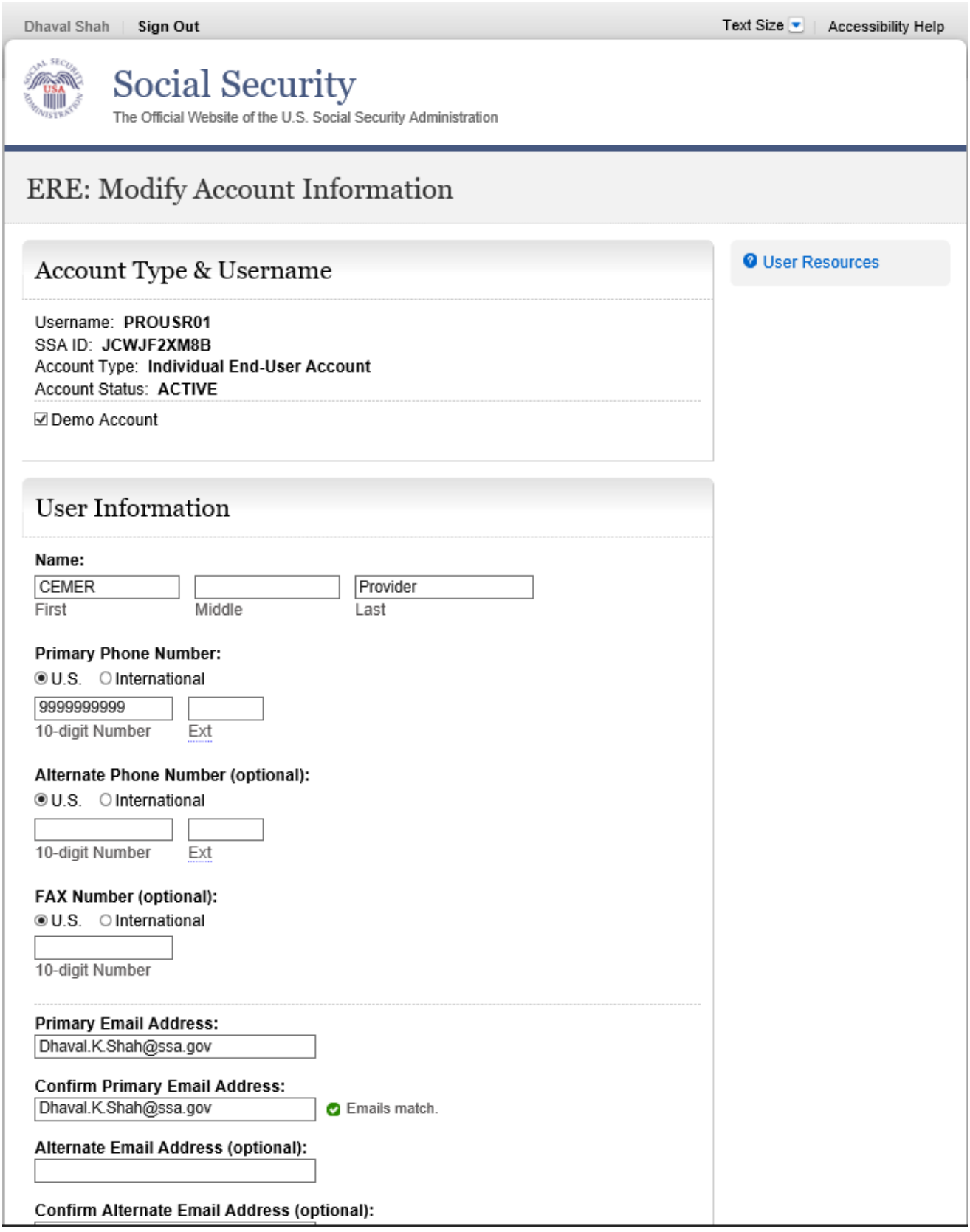


Change Your Password

Change Your Password Confirmation



Modify Account



Confirm Alternate Email Address (optional):

Organization Information

Organization Type:
Other

Organization Name:
Shah Medical Associates

Department (optional):
General

Position (optional):
Doctor

Address:

Country:
United States or U.S. Territory

Street Address:
Street Line 1: 6401 Security Blvd
Street Line 2:
Add Line

City/Town: Woodlawn
State/Territory: MD
ZIP Code: 21244

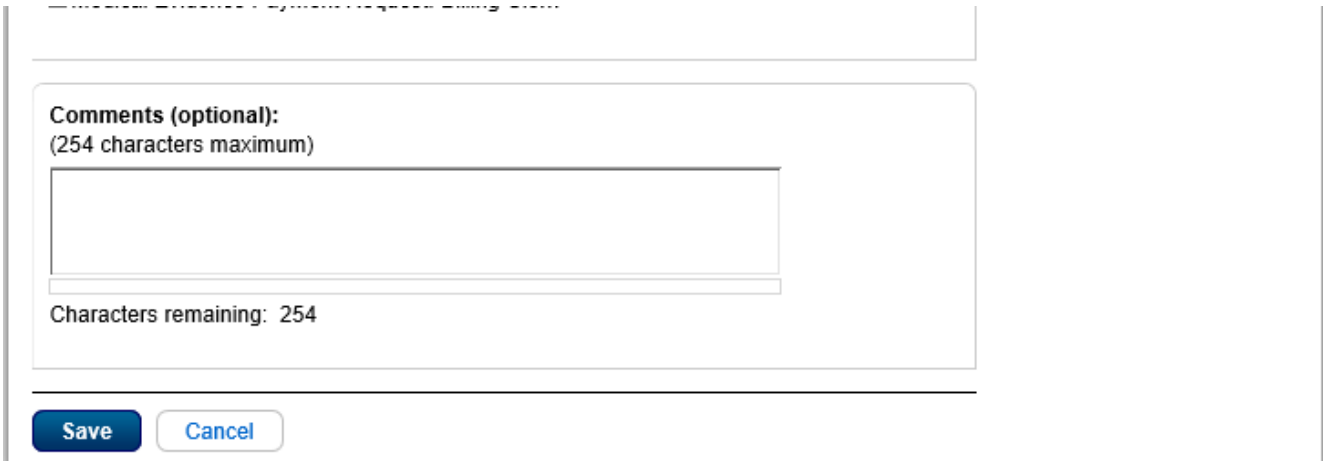
Primary Site:
MD - Timonium DDS [S23]

Primary Site Contact:
Account, Sponsor (SPONBPD1)

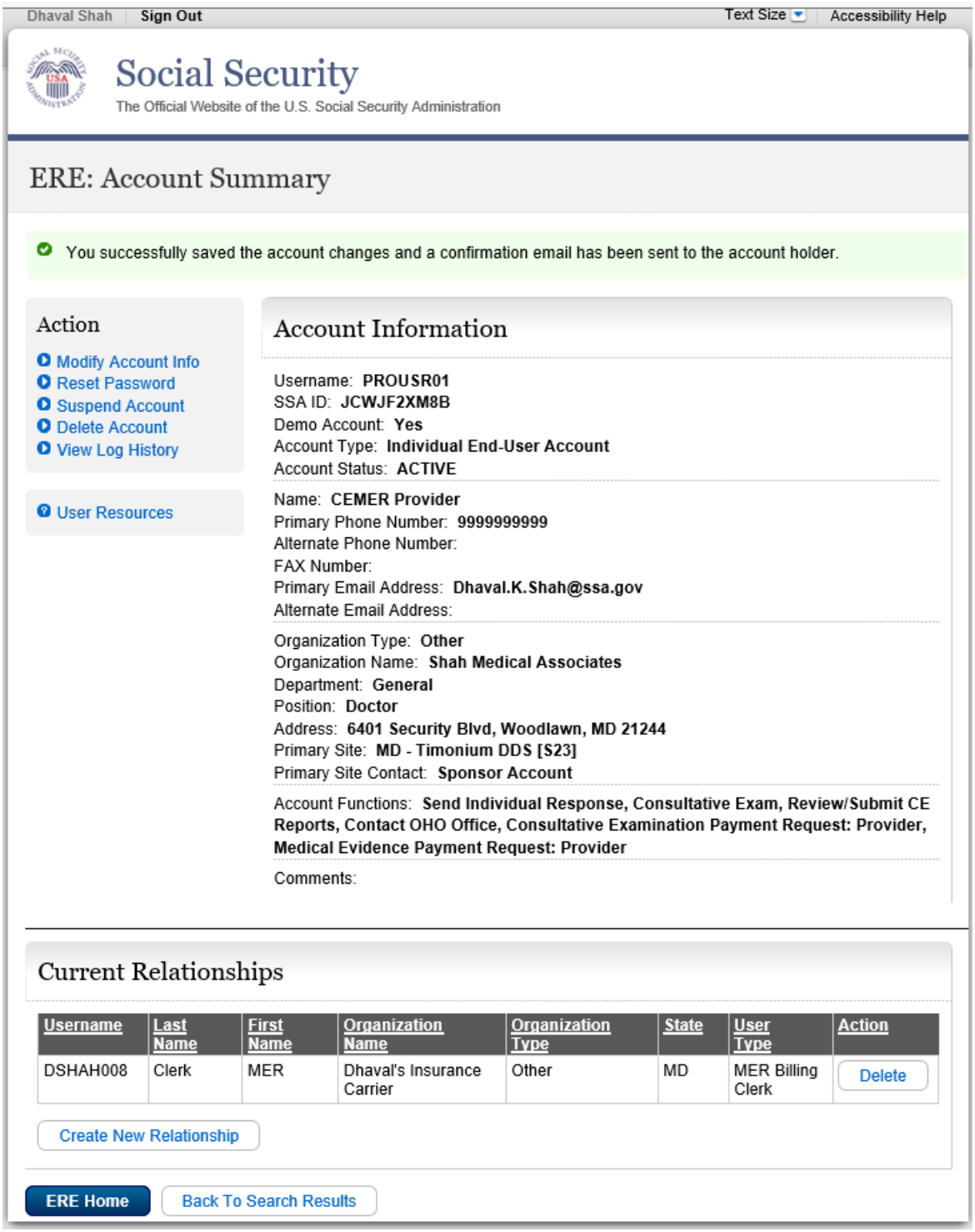
Account Functions

Select the functions that apply to the user. You must select at least one option.

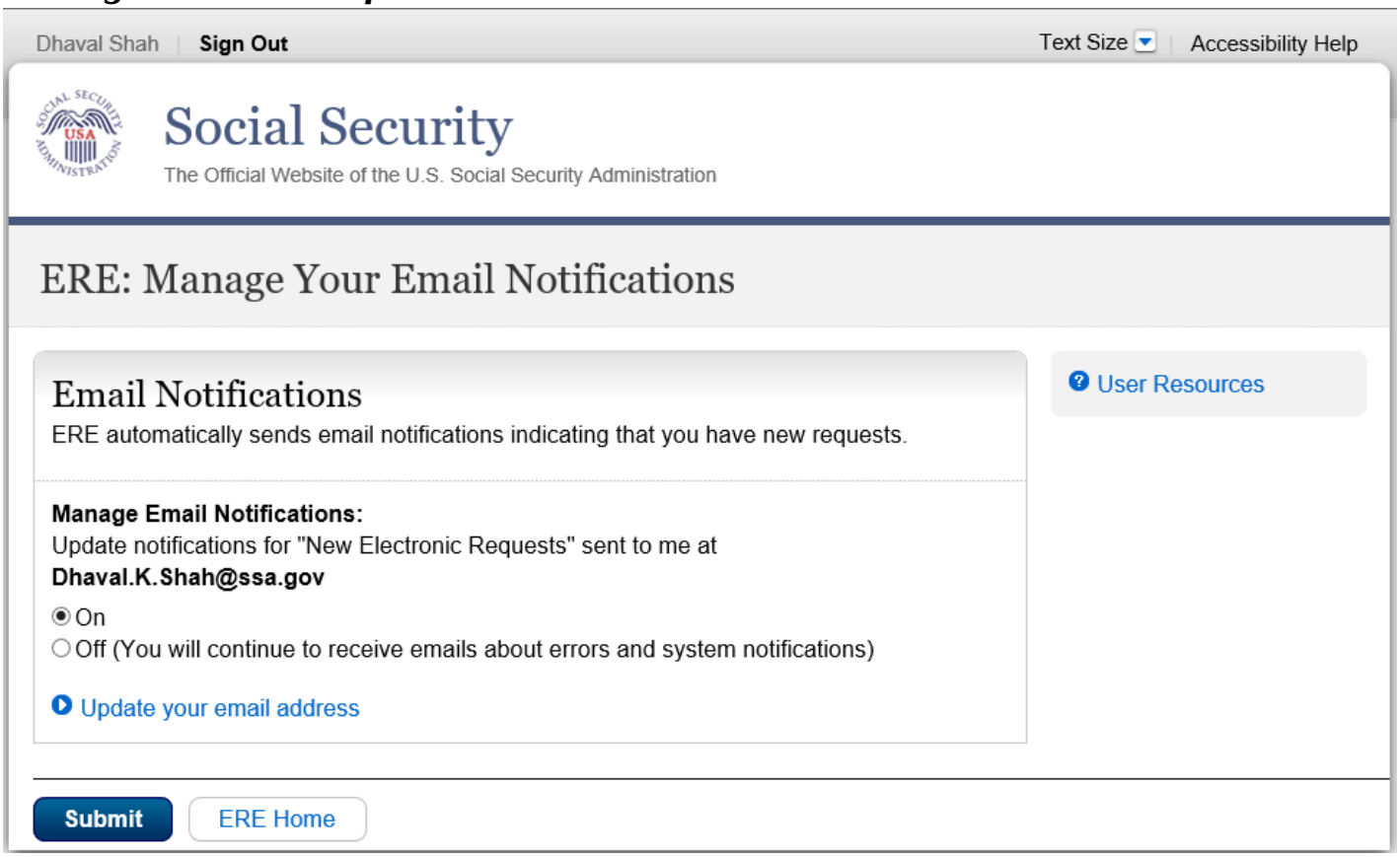
- [x] Send Individual Response
- [x] Send Grouped Response
- [x] Consultative Exam
- [ ] Prepare Consultative Exam Report for Provider
- [x] Review/Submit CE Reports
- [x] Consultative Exam with Scanned Signatures
- [ ] Secure Messaging
- [x] Contact OHO Office
- [x] Consultative Examination Payment Request: Provider
- [ ] Consultative Examination Payment Request: Billing Clerk
- [x] Medical Evidence Payment Request: Provider
- [ ] Medical Evidence Payment Request: Billing Clerk


Comments (optional):
(254 characters maximum)
Characters remaining: 254
Save
Cancel

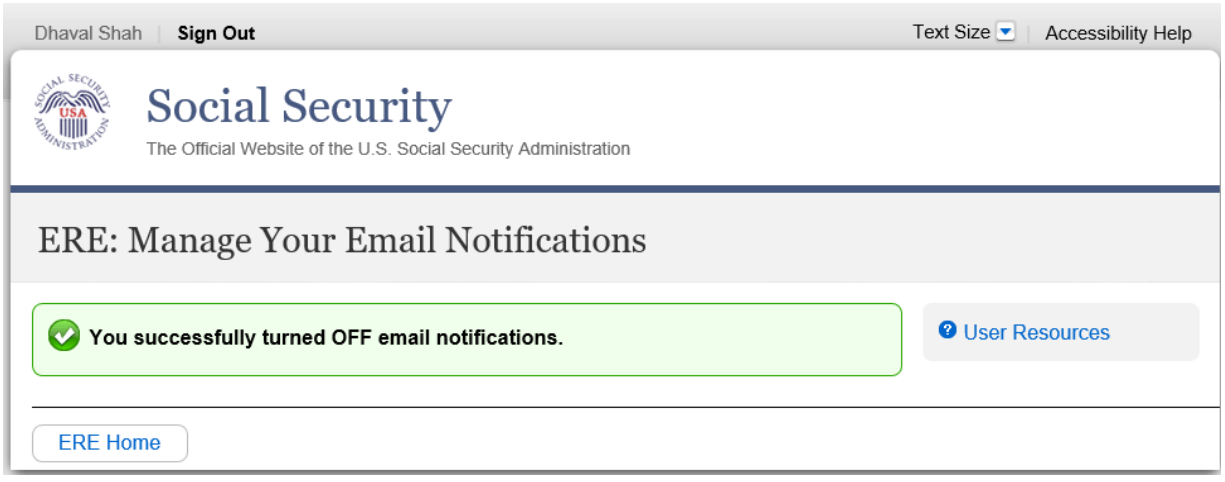
Modify Account Confirmation



Manage E-Mail Notification



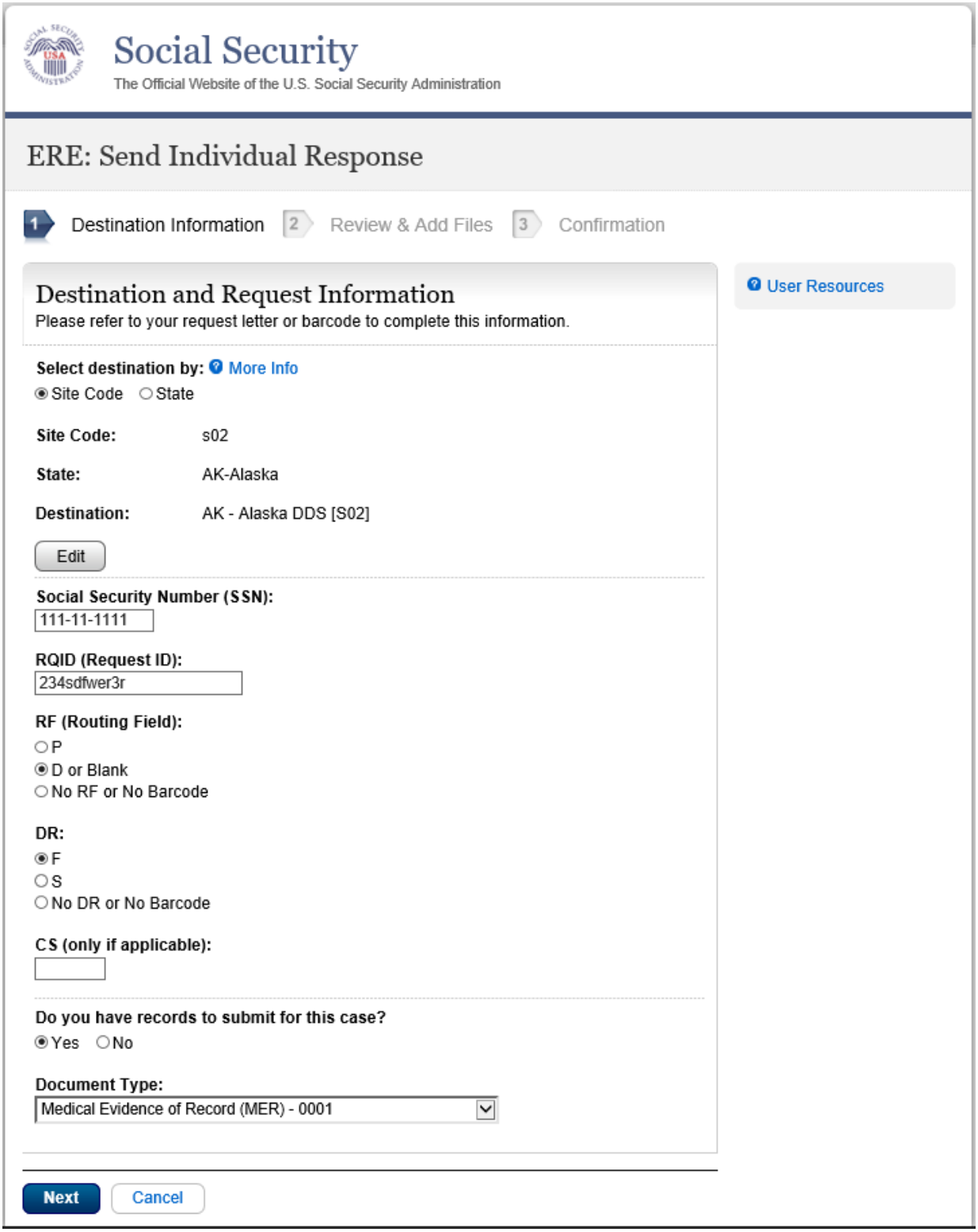
Manage E-Mail Notification Confirmation



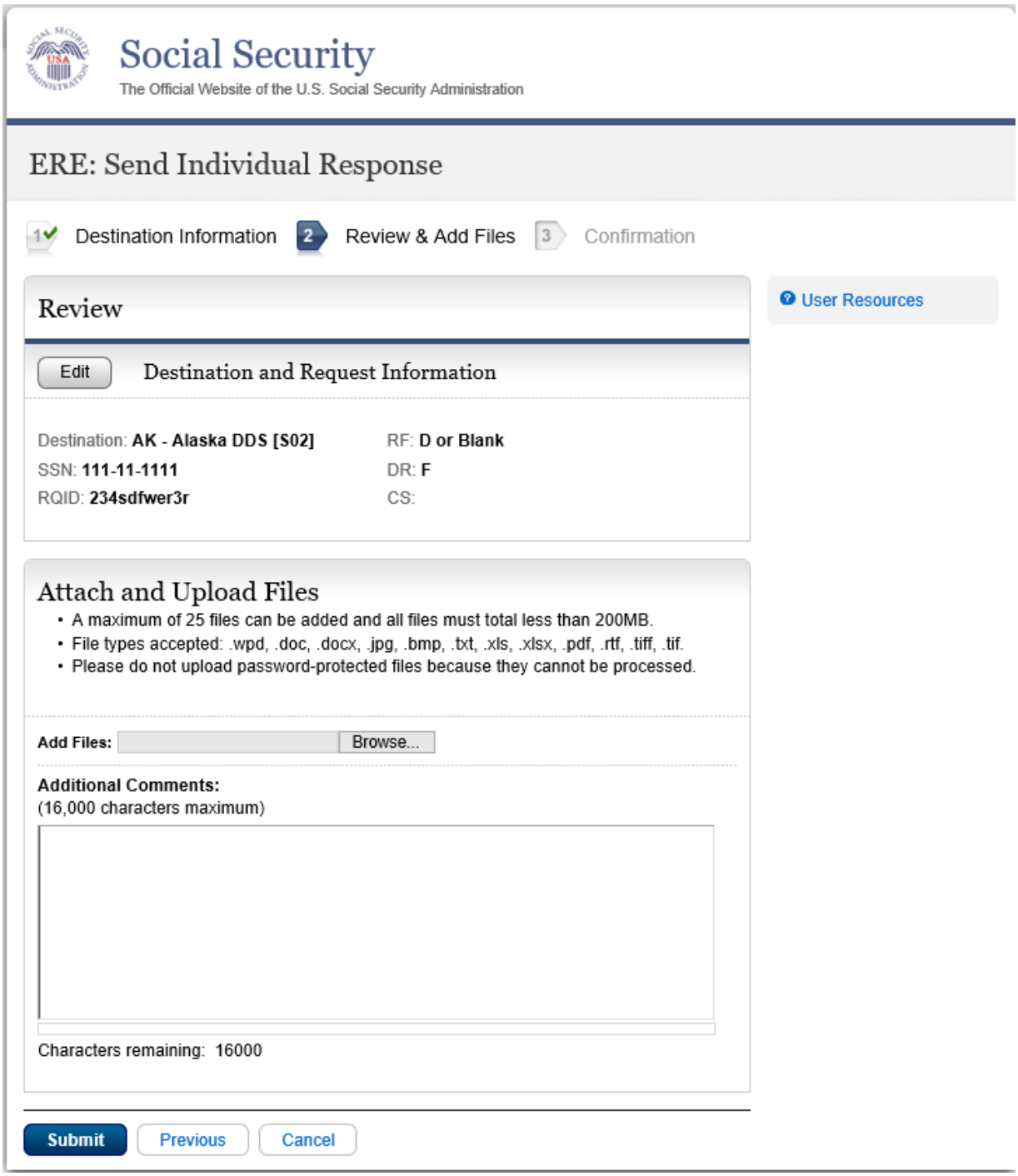
Evidence Services

Send Individual Response

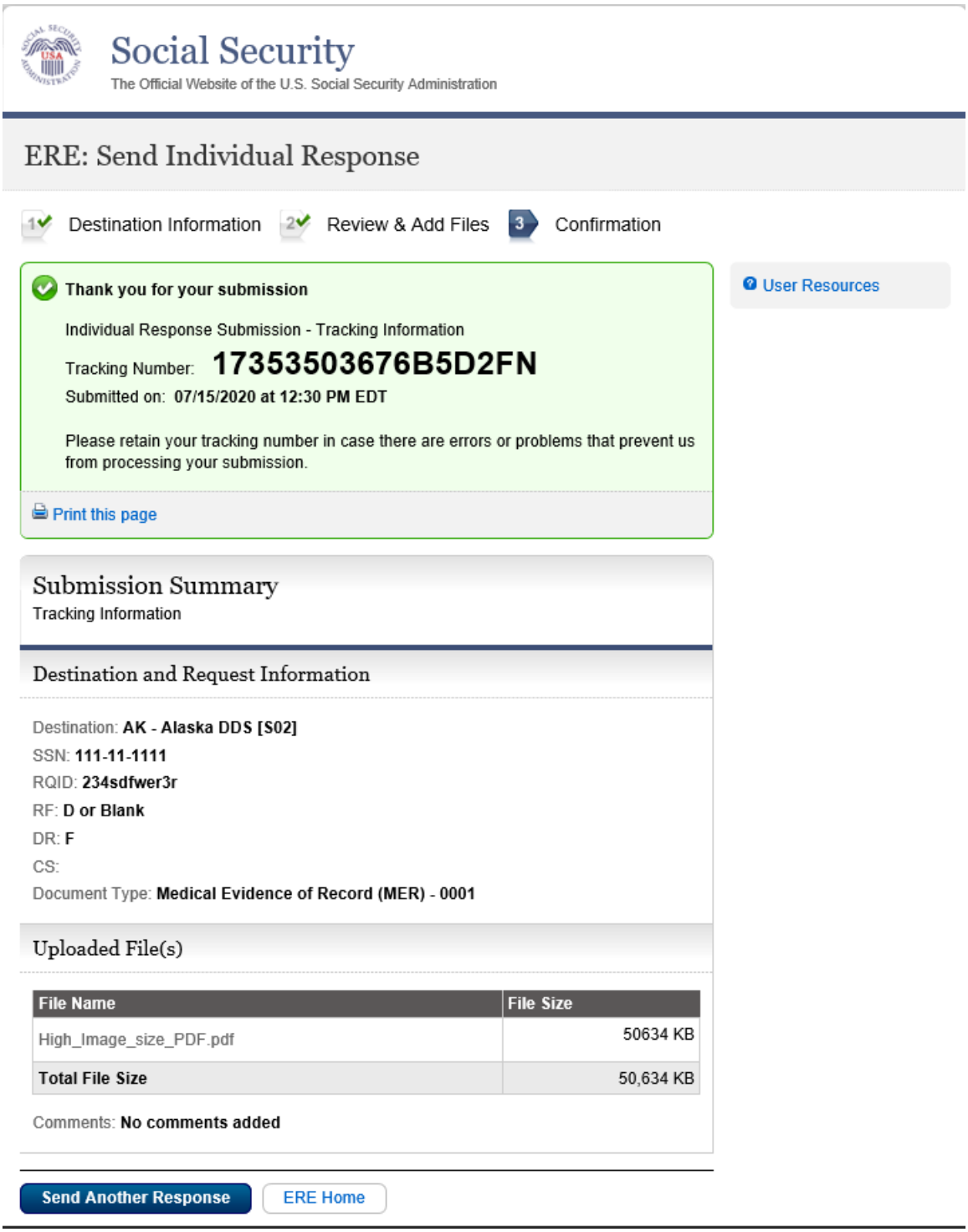
Destination and Request Information



Review & Add Information



Tracking Page (no fiscal)



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

ERE: Send Individual Response

1 Destination Information 2 Review & Add Files 3 Confirmation

User Resources

Thank you for your submission

Individual Response Submission - Tracking Information

Tracking Number: **17353503676B5D2FN**

Submitted on: **07/15/2020 at 12:30 PM EDT**

Please retain your tracking number in case there are errors or problems that prevent us from processing your submission.

Print this page

Submission Summary

Tracking Information

Destination and Request Information

Destination: **AK - Alaska DDS [S02]**
SSN: **111-11-1111**
RQID: **234sdfwer3r**
RF: **D or Blank**
DR: **F**
CS:
Document Type: **Medical Evidence of Record (MER) - 0001**

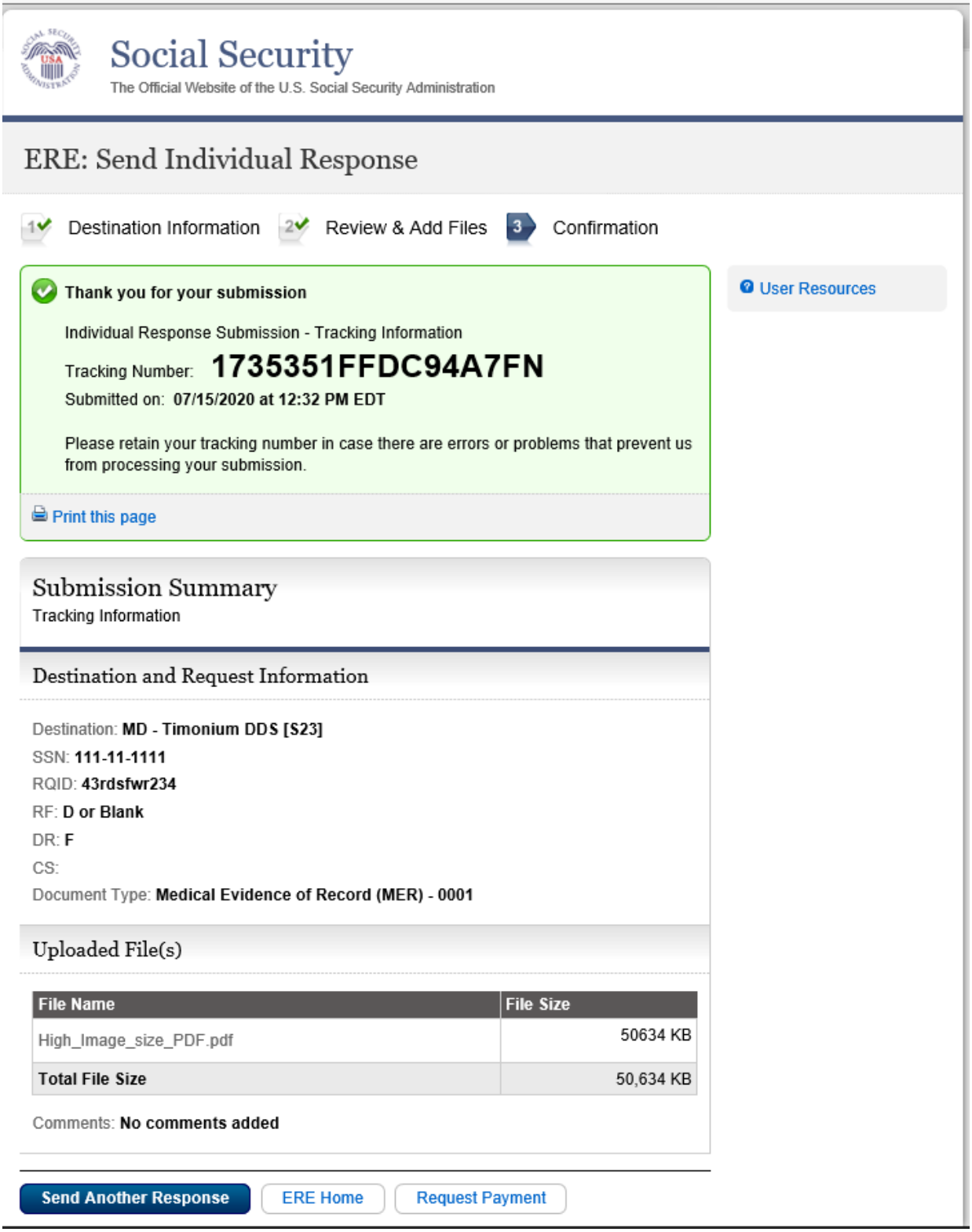
Uploaded File(s)

File Name	File Size
High_Image_size_PDF.pdf	50634 KB
Total File Size	50,634 KB

Comments: **No comments added**

Send Another Response ERE Home

Tracking Page (fiscal)



Social Security

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

ERE: Send Individual Response

1 Destination Information 2 Review & Add Files 3 Confirmation

Thank you for your submission

Individual Response Submission - Tracking Information

Tracking Number: **1735351FFDC94A7FN**

Submitted on: **07/15/2020 at 12:32 PM EDT**

Please retain your tracking number in case there are errors or problems that prevent us from processing your submission.

Print this page

User Resources

Submission Summary

Tracking Information

Destination and Request Information

Destination: **MD - Timonium DDS [S23]**

SSN: **111-11-1111**

RQID: **43rdsfwr234**

RF: **D or Blank**

DR: **F**

CS:

Document Type: **Medical Evidence of Record (MER) - 0001**

Uploaded File(s)

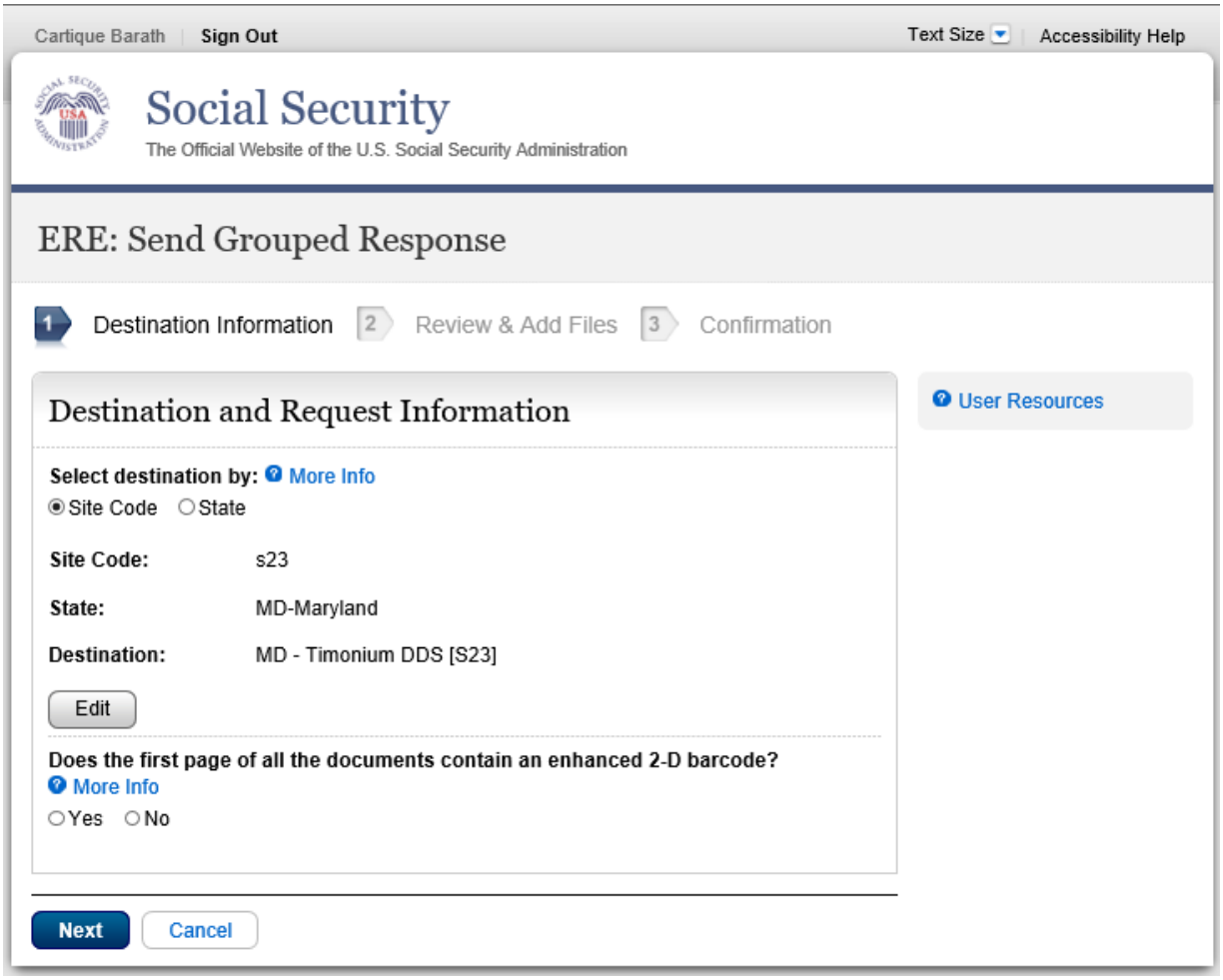
File Name	File Size
High_Image_size_PDF.pdf	50634 KB
Total File Size	50,634 KB

Comments: **No comments added**

Send Another Response ERE Home Request Payment

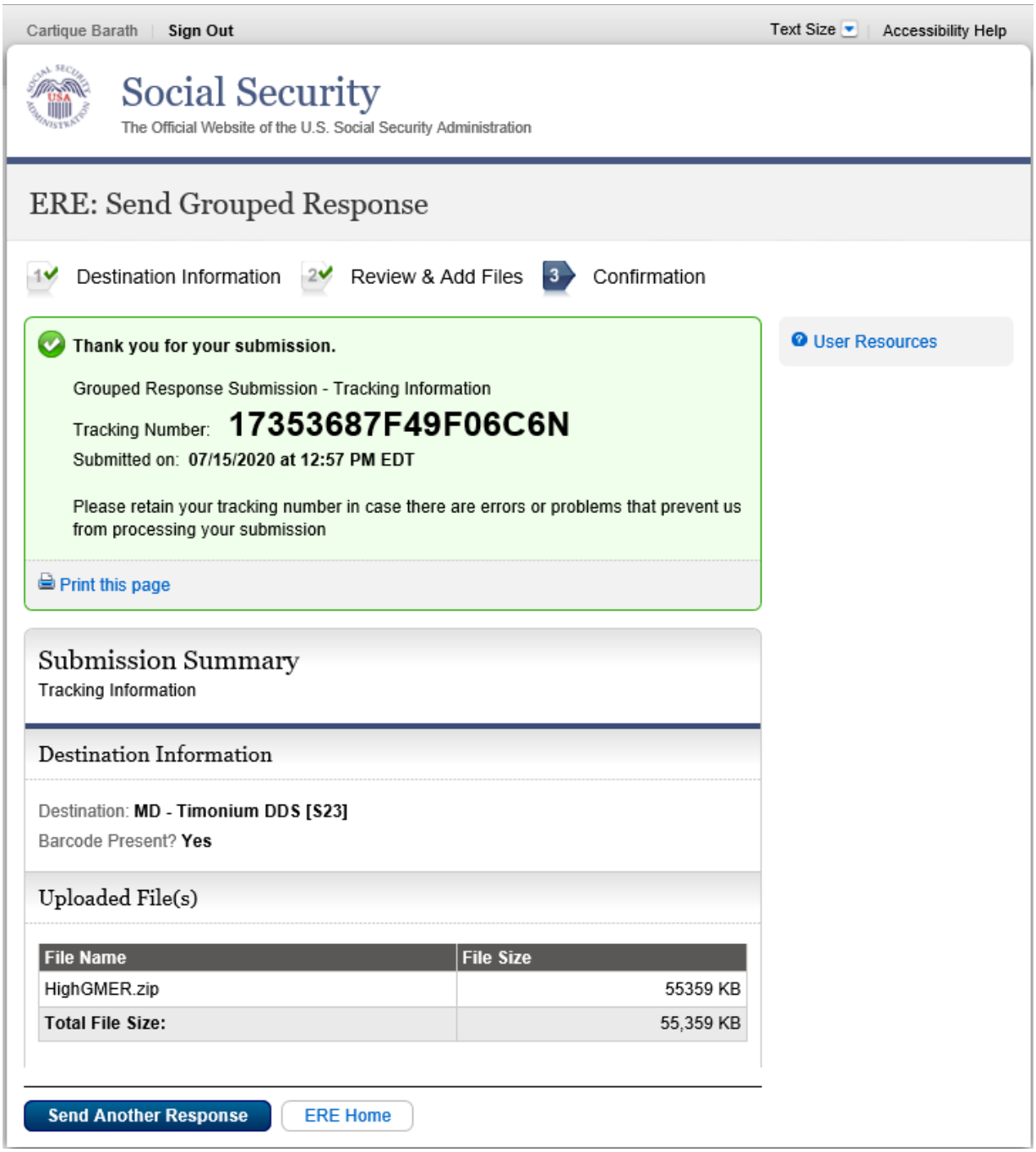
Send Grouped Response

Destination Information



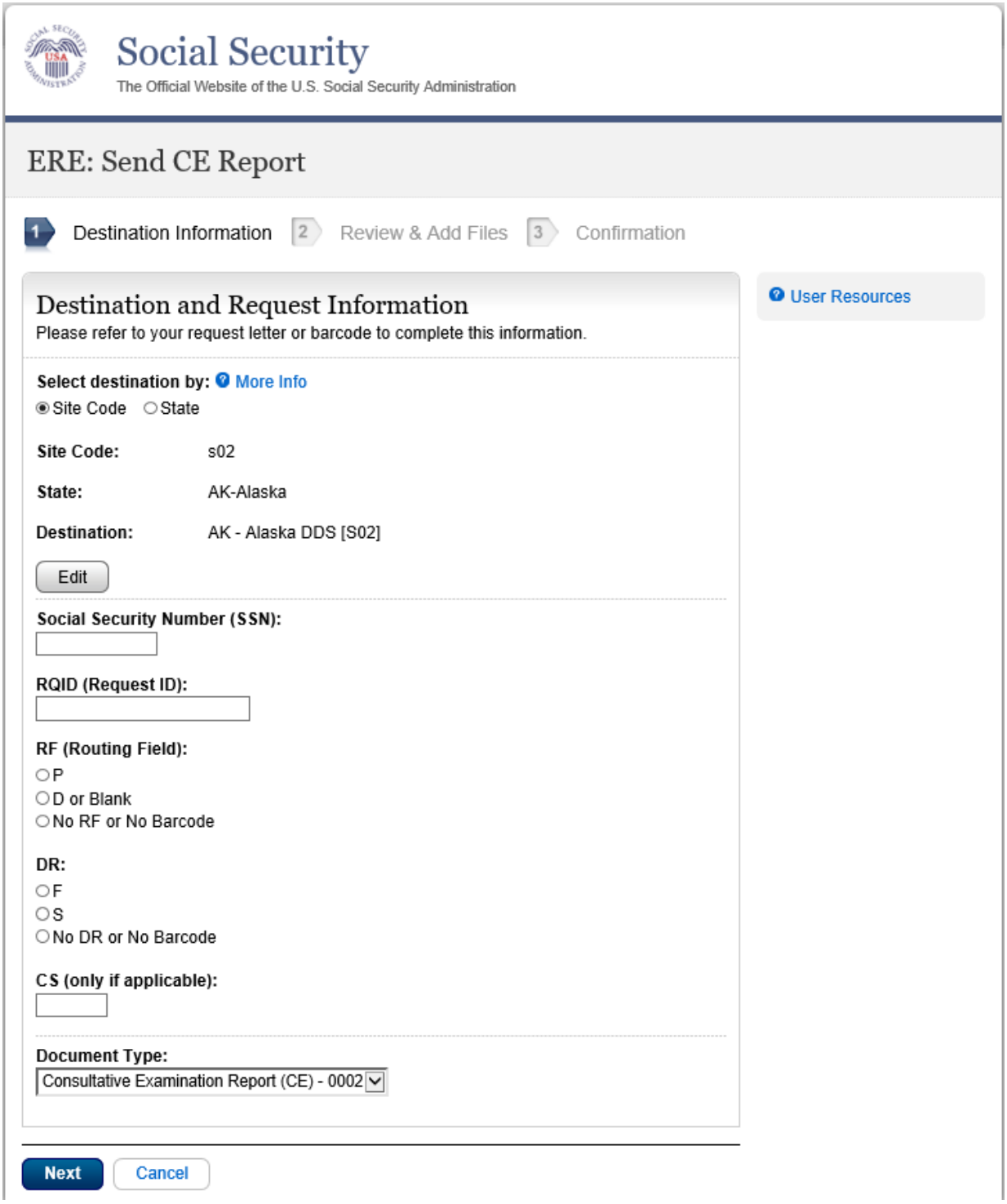
Review & Add Information

Confirmation

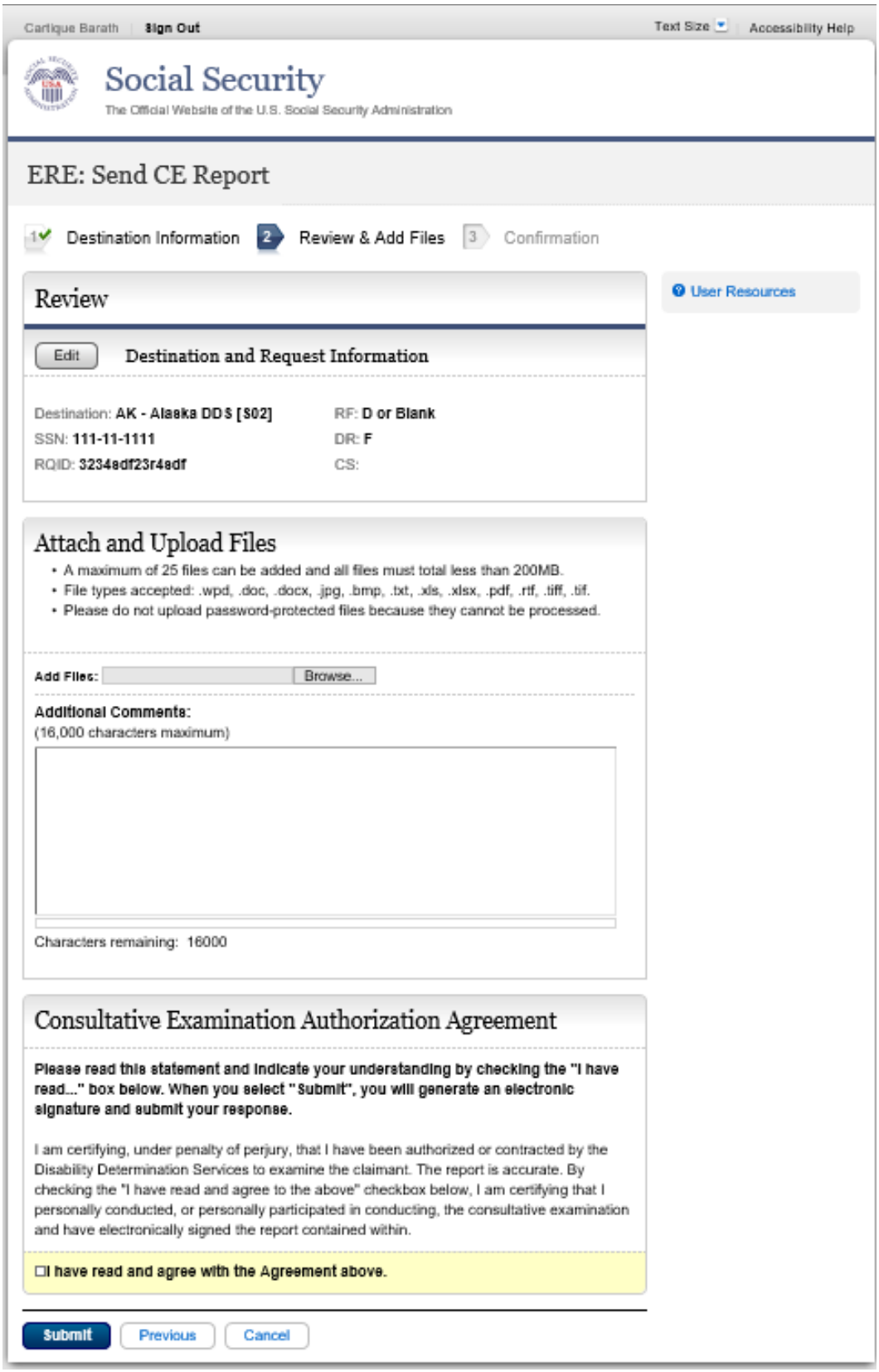


Send CE Report

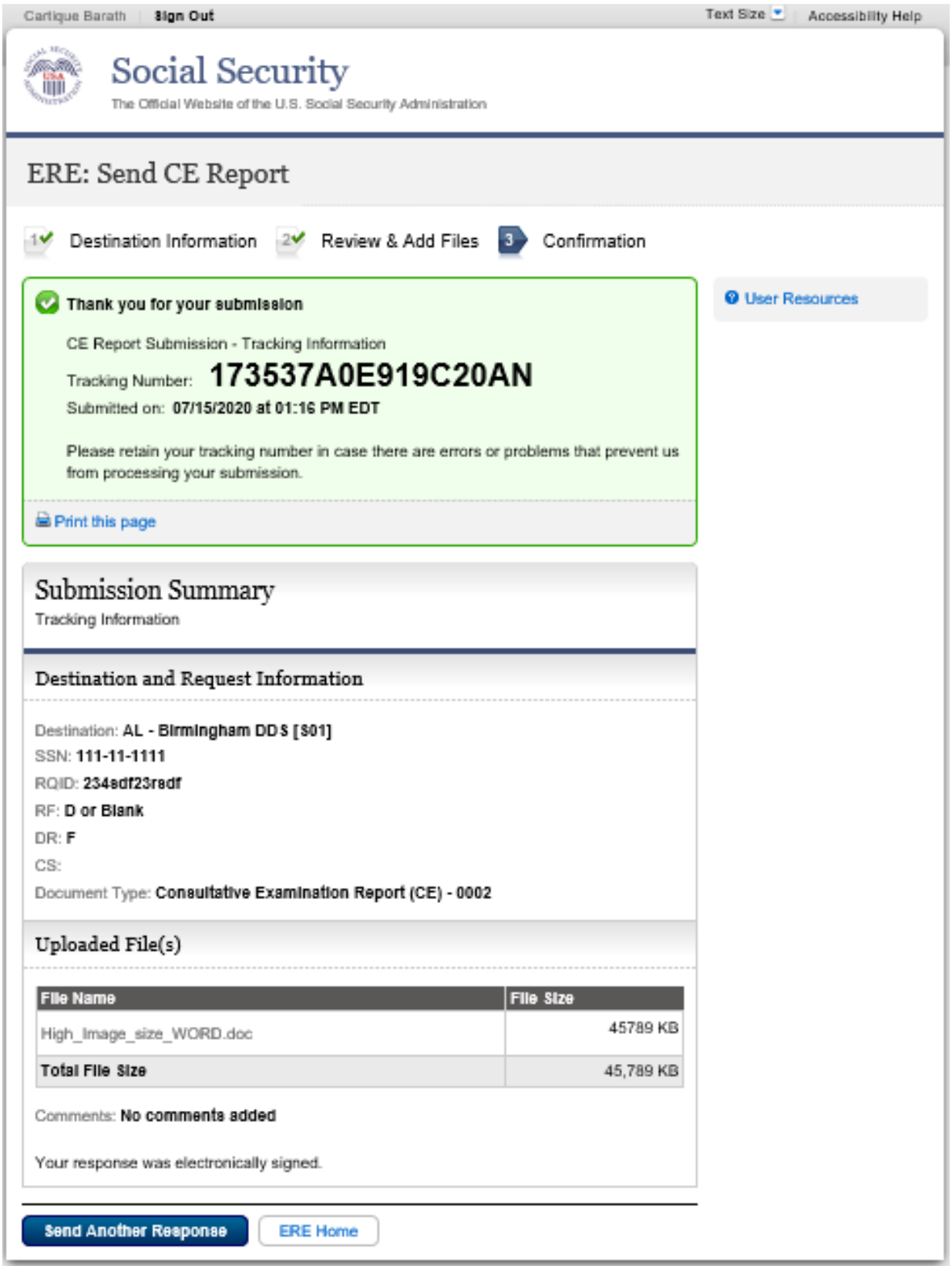
Destination & Request Information



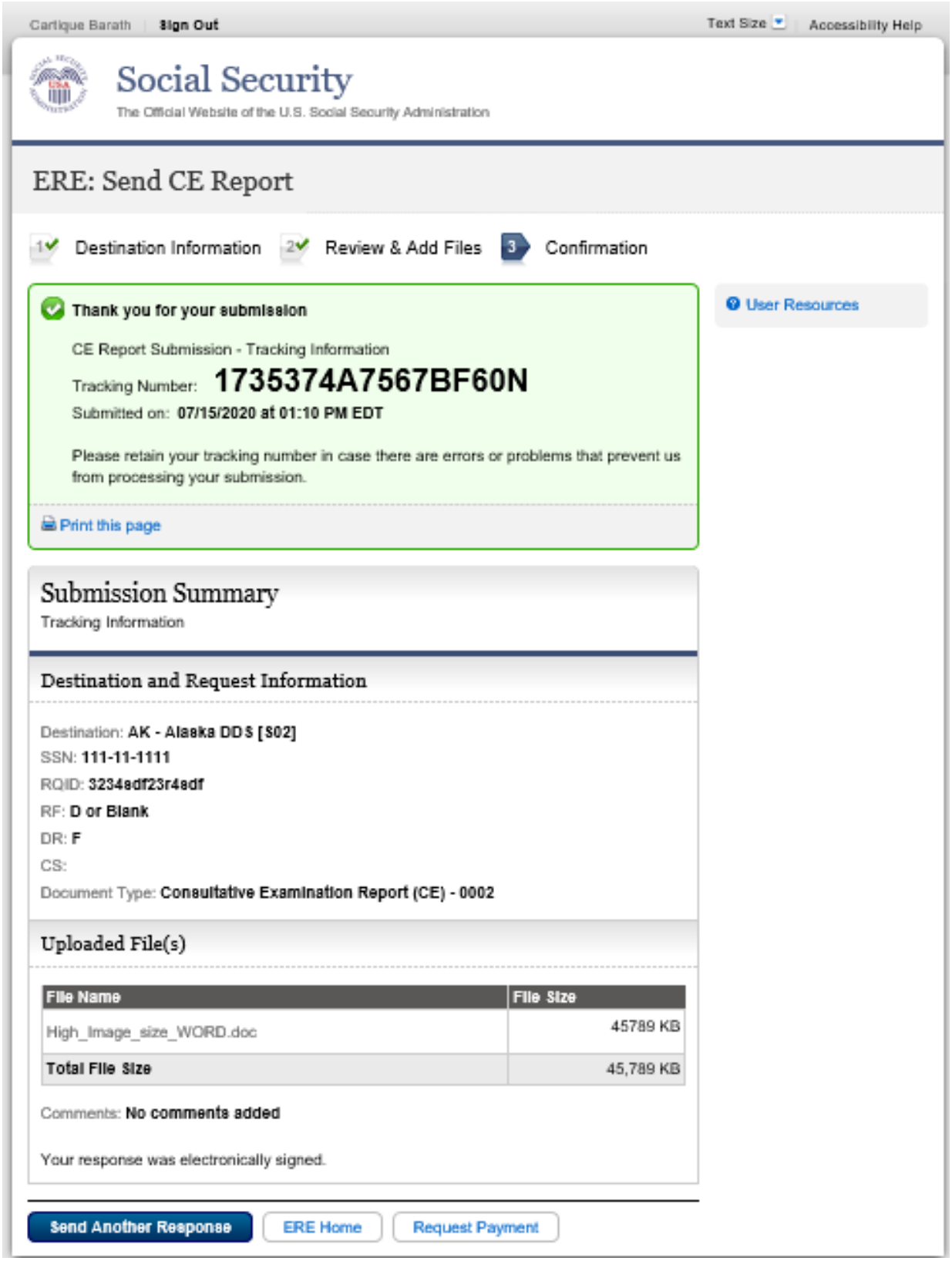
Review & Add Information



Tracking Page (no fiscal)

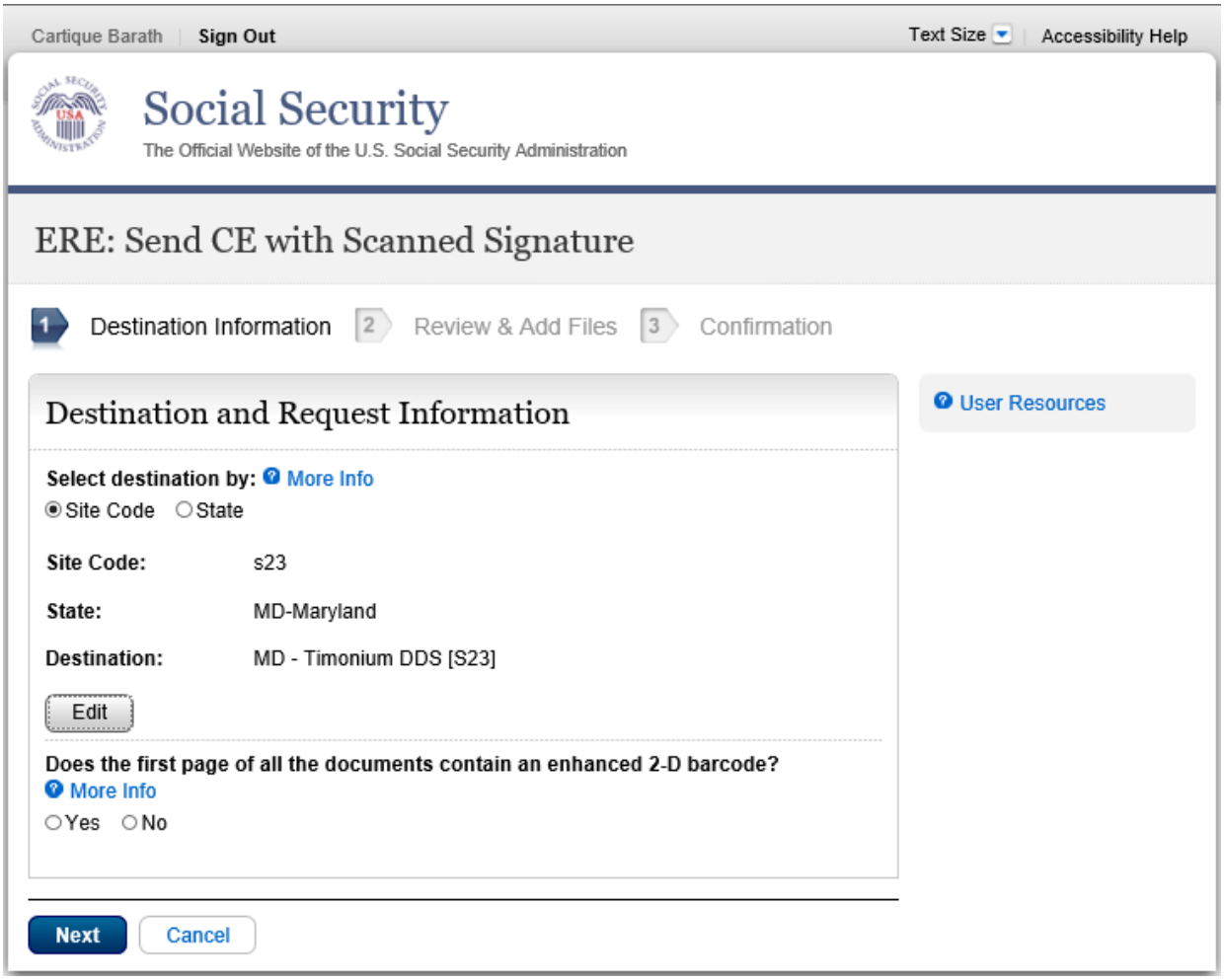


Tracking Page (with fiscal)

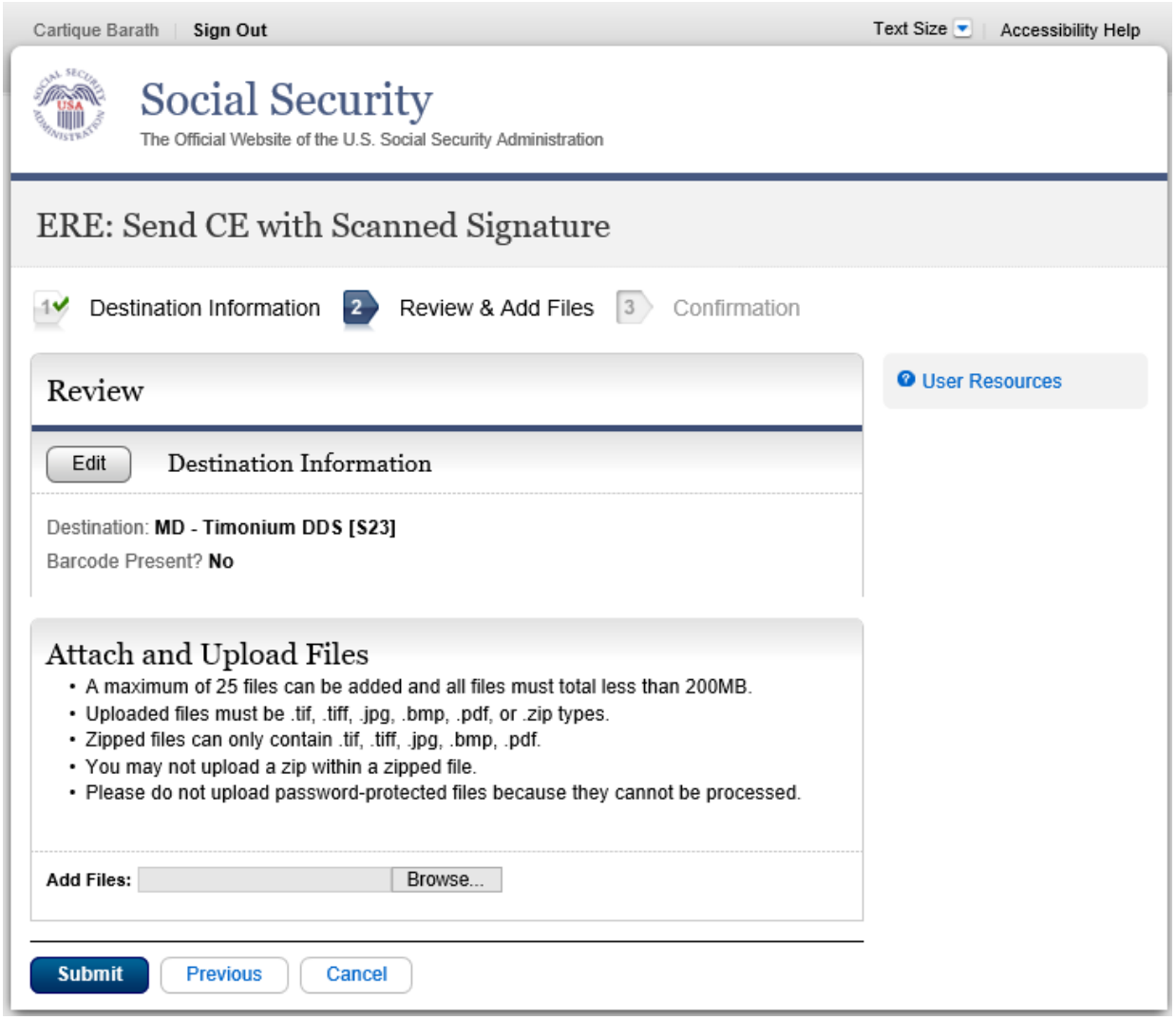


Send CE Report(s) with Scanned Signature

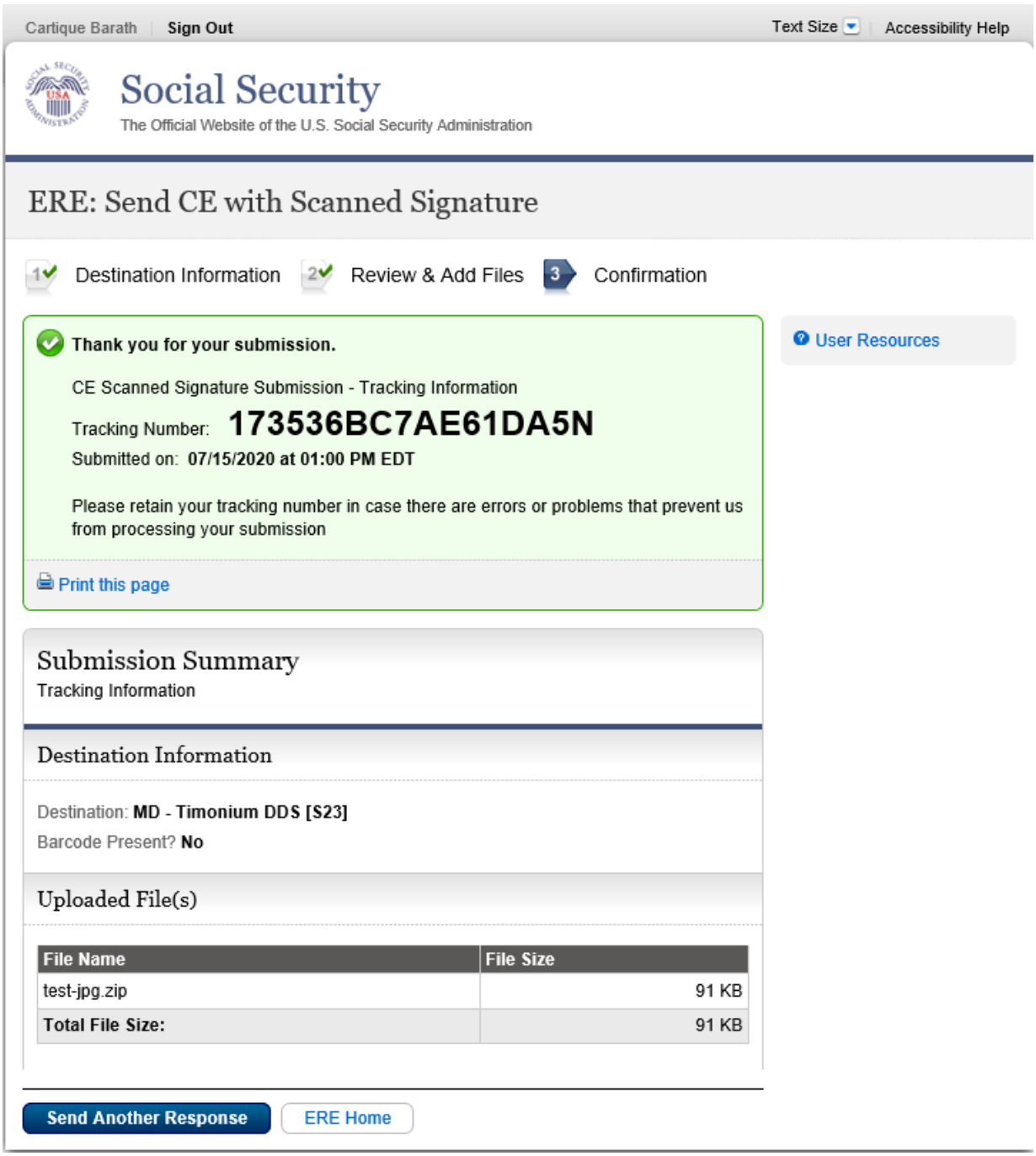
Destination Information



Review & Add Information

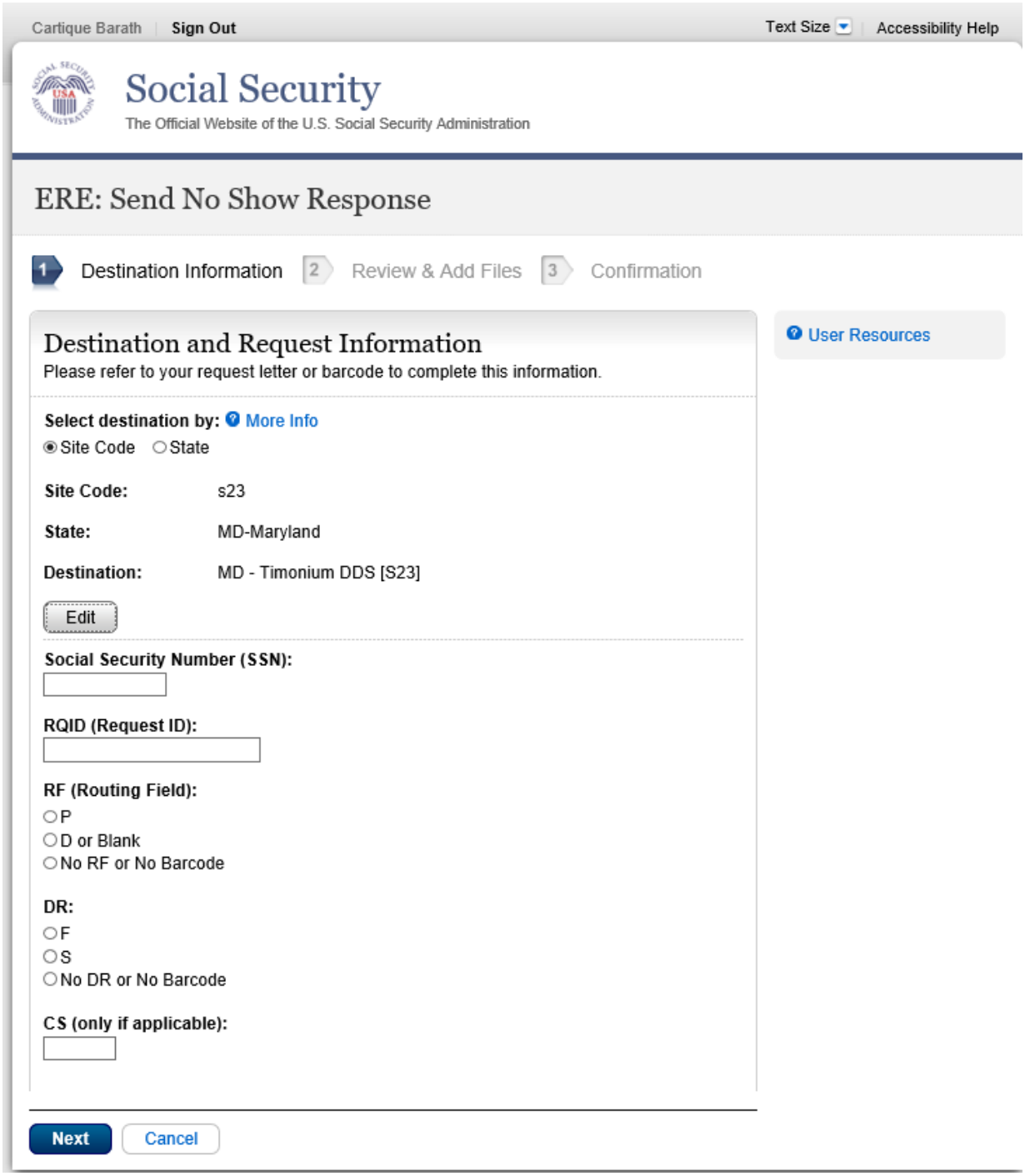


Confirmation

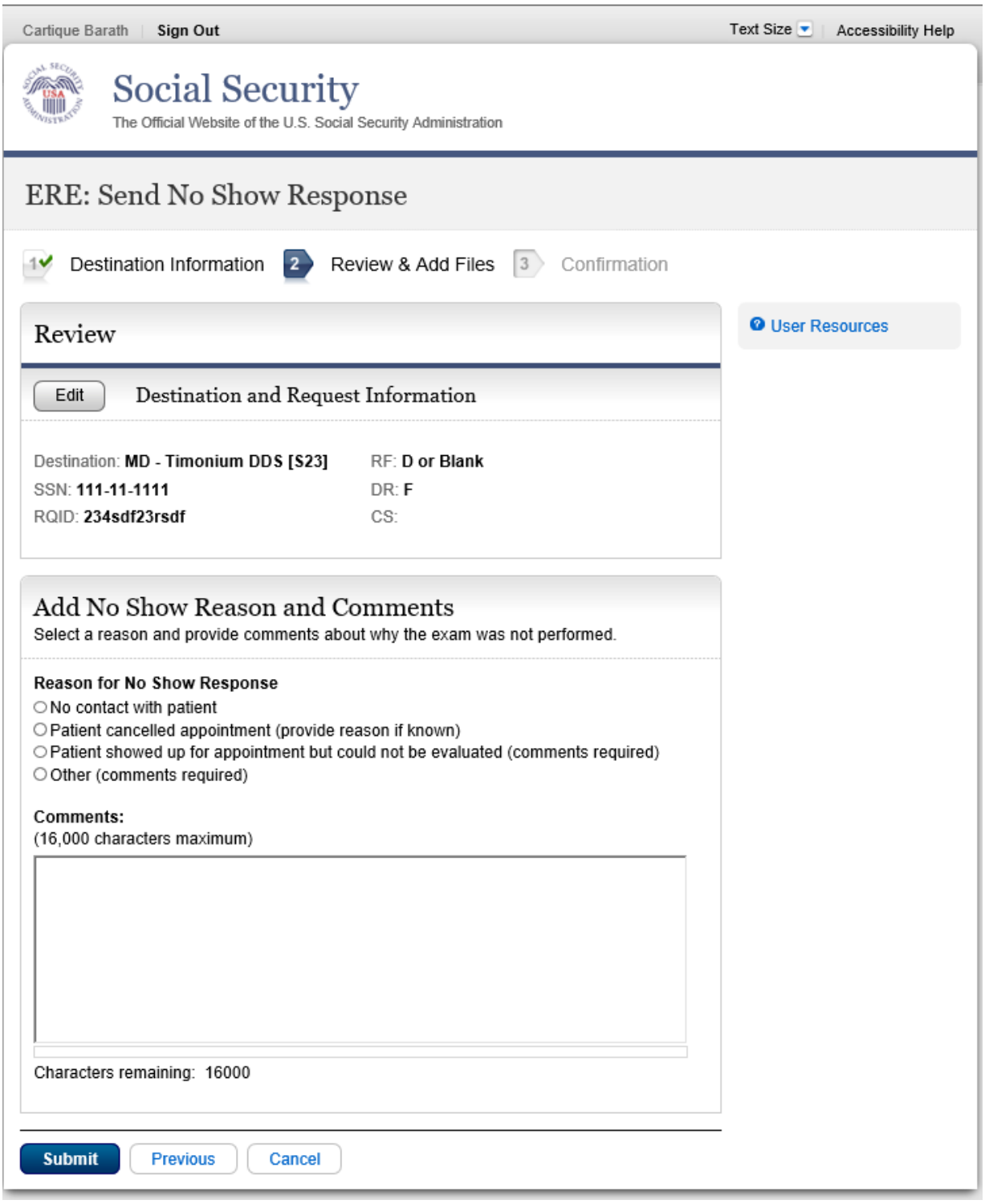


Send CE No Show Response

Destination and Request Information



Review & Add Information



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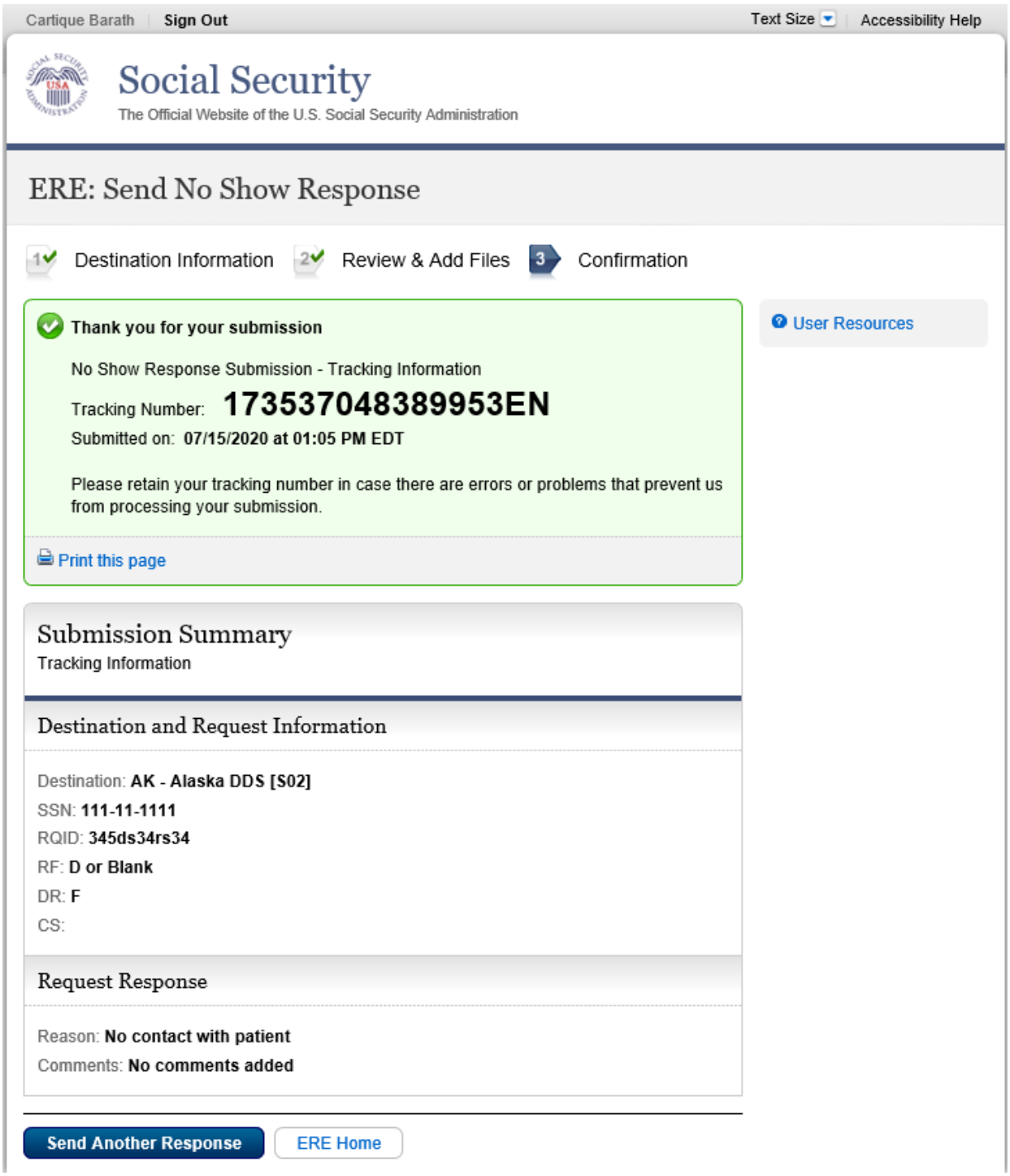
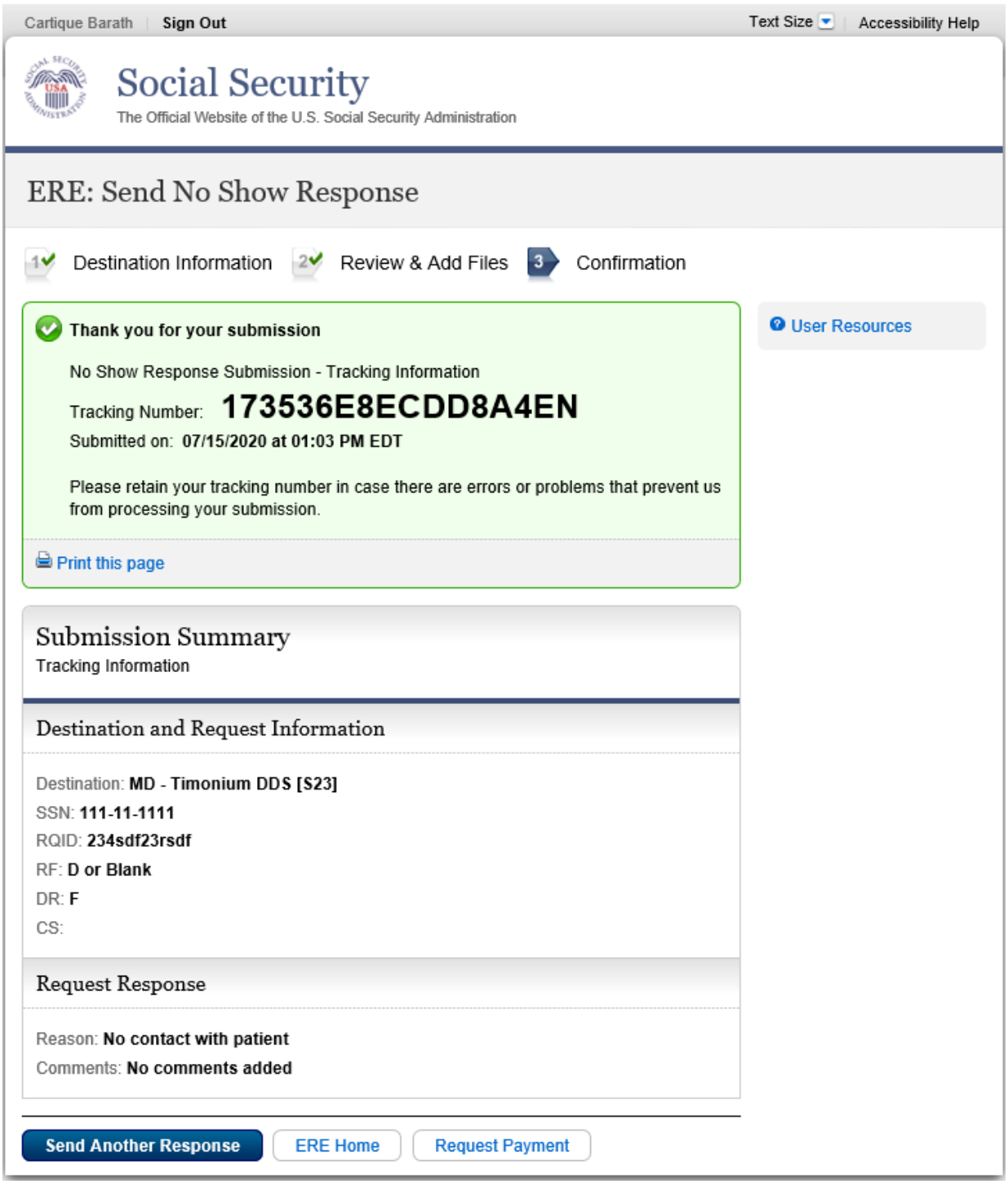
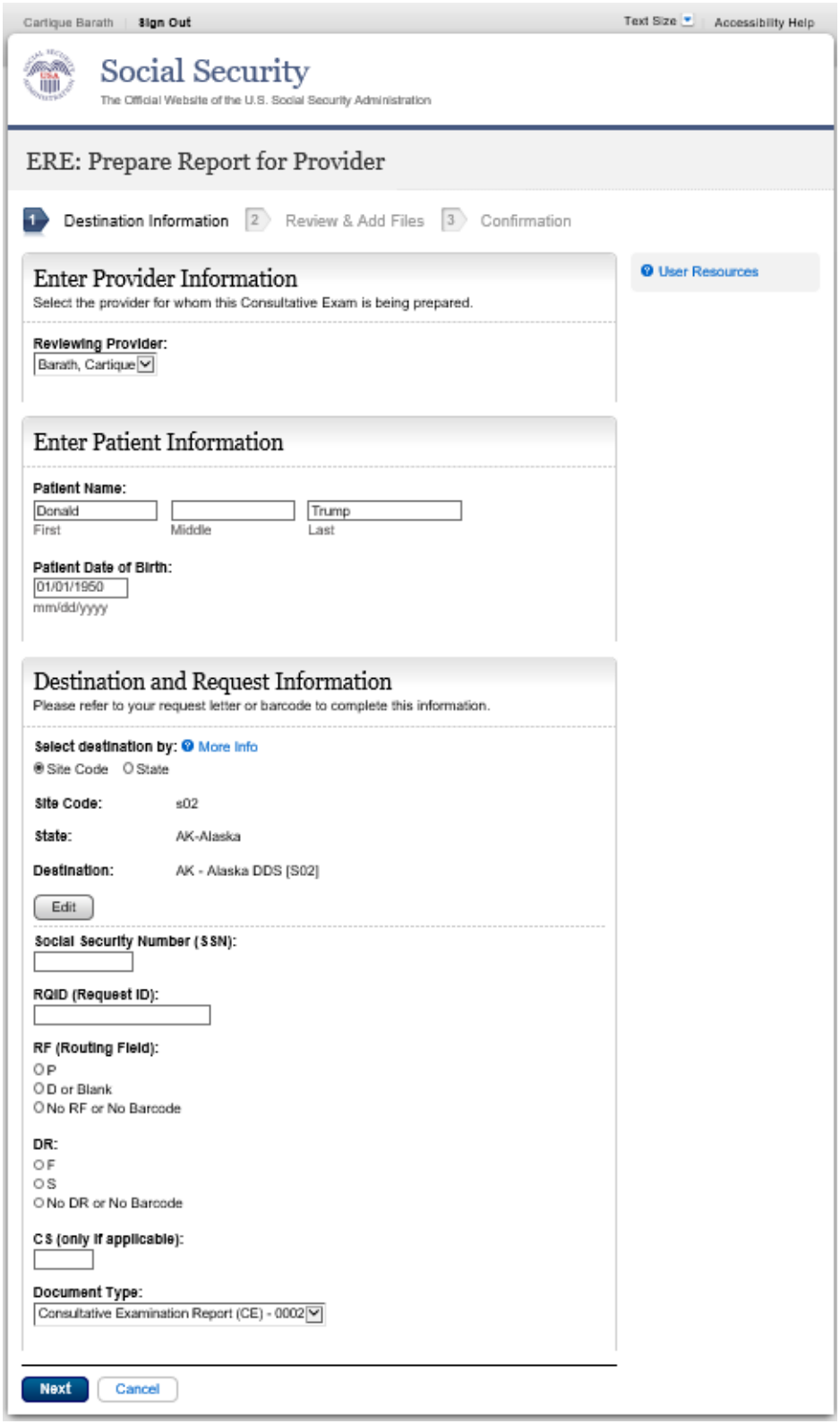


Tracking Page (fiscal)

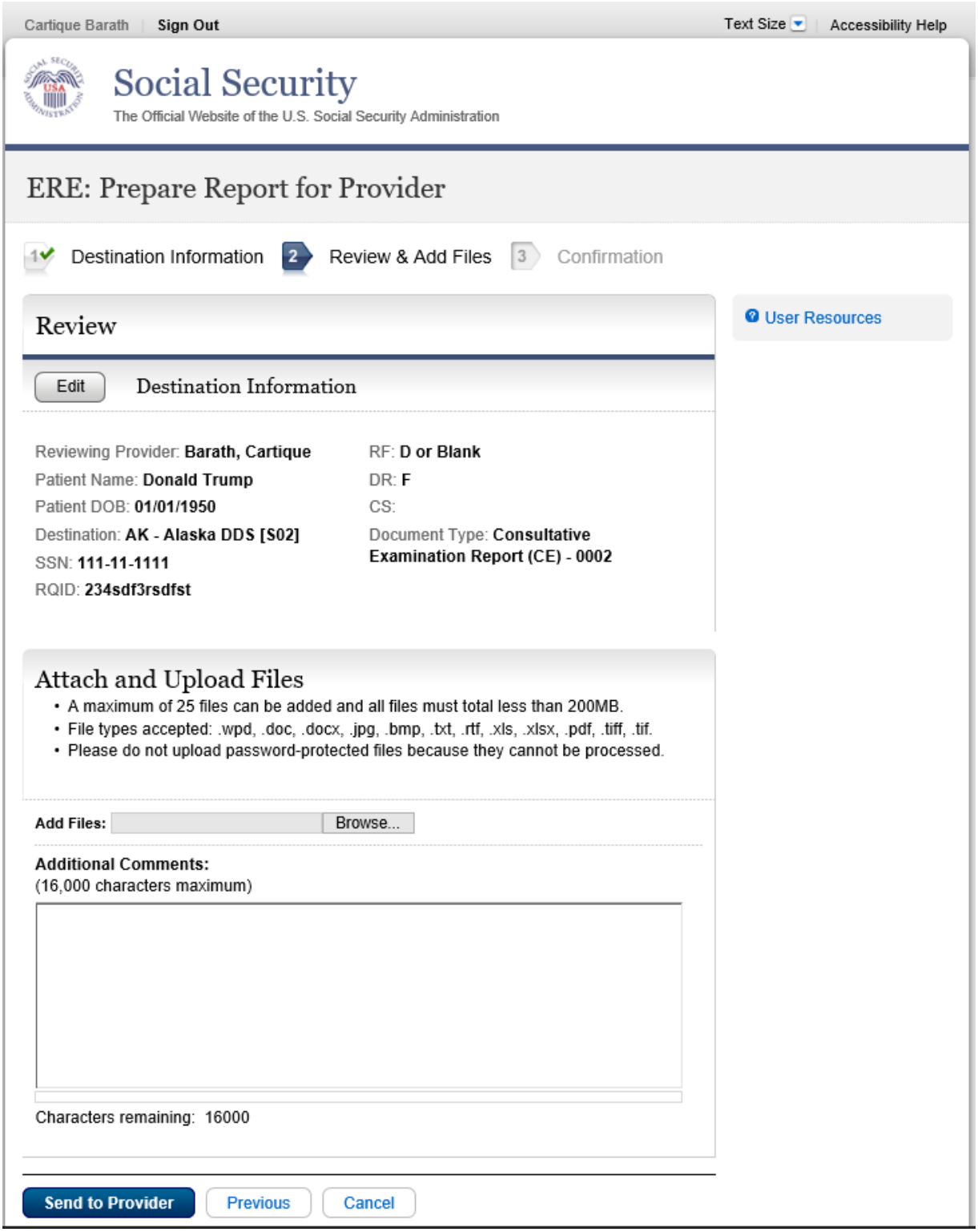


Prepare CE Report for Provider

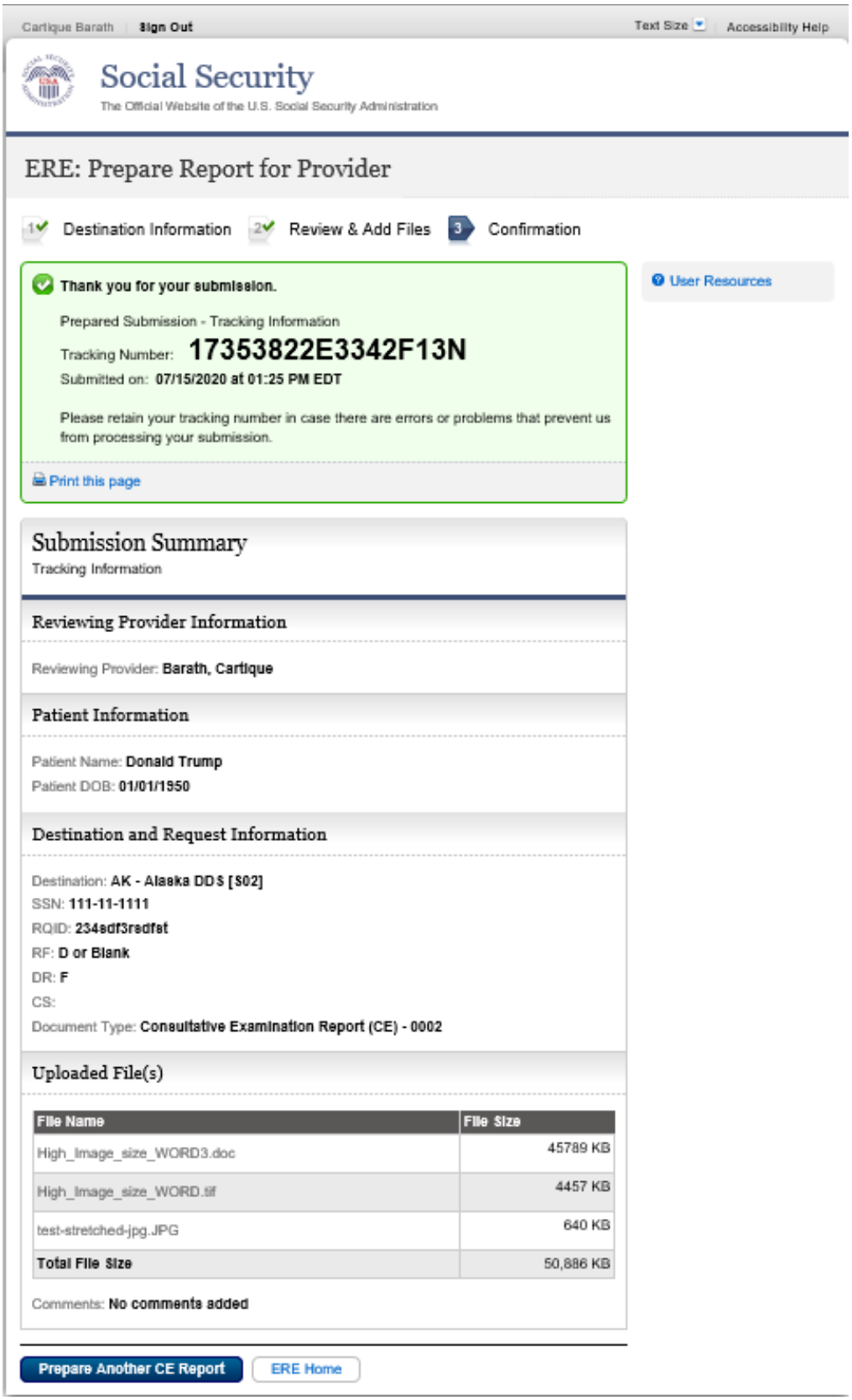
Destination Information



Review & Add Information



Tracking Page



Cartique Barath | Sign Out Text Size | Accessibility Help

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

ERE: Prepare Report for Provider

1 Destination Information 2 Review & Add Files 3 Confirmation

Thank you for your submission.

Prepared Submission - Tracking Information

Tracking Number: **17353822E3342F13N**

Submitted on: **07/15/2020 at 01:25 PM EDT**

Please retain your tracking number in case there are errors or problems that prevent us from processing your submission.

Print this page

User Resources

Submission Summary

Tracking Information

Reviewing Provider Information

Reviewing Provider: **Barath, Cartique**

Patient Information

Patient Name: **Donald Trump**

Patient DOB: **01/01/1950**

Destination and Request Information

Destination: **AK - Alaska DDS [S02]**

SSN: **111-11-1111**

RQID: **234sdf3redfst**

RF: **D or Blank**

DR: **F**

CS:

Document Type: **Consultative Examination Report (CE) - 0002**

Uploaded File(s)

File Name	File Size
High_Image_size_WORD3.doc	45789 KB
High_Image_size_WORD.tif	4457 KB
test-stretched-jpg.JPG	640 KB
Total File Size	50,886 KB

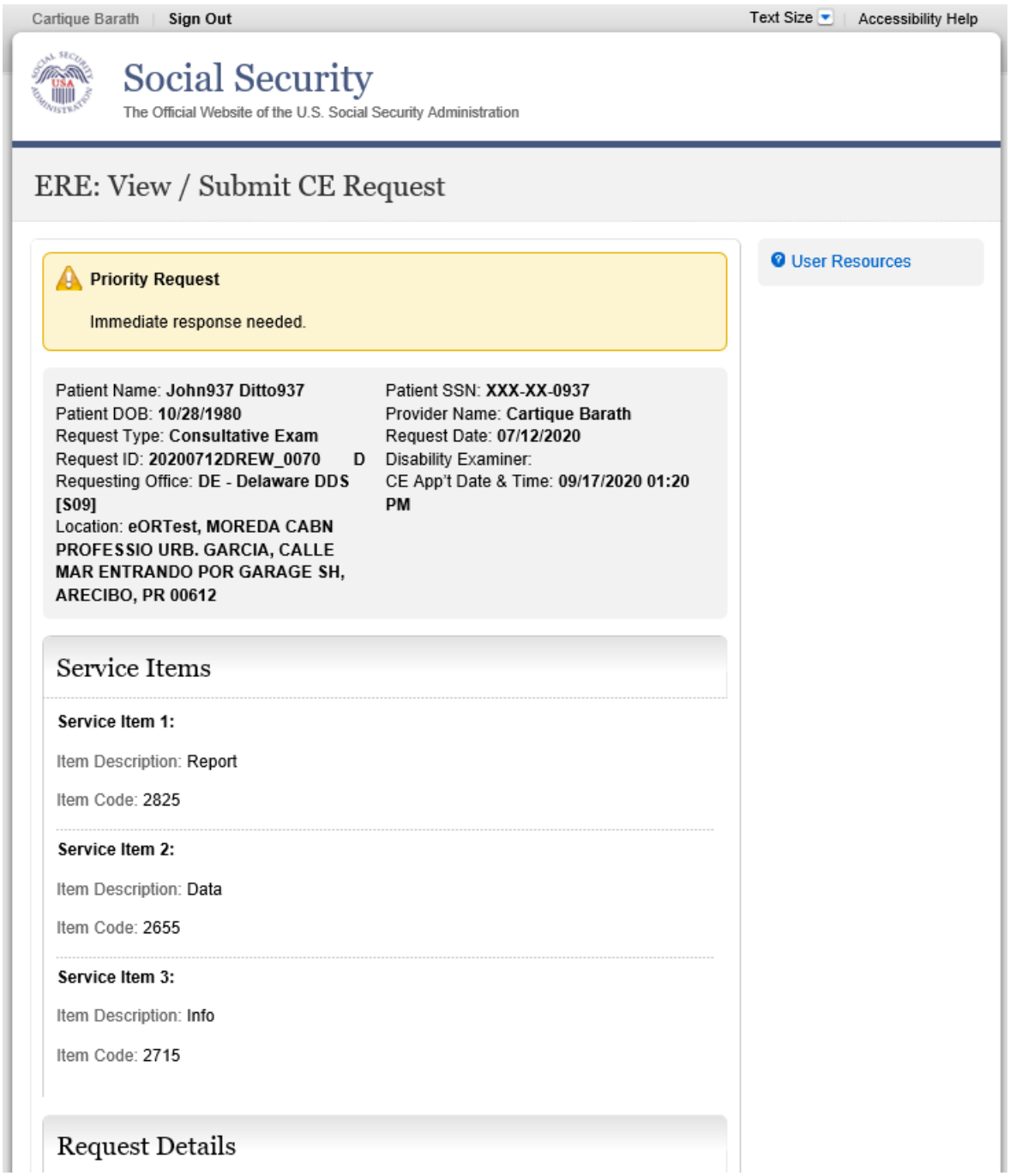
Comments: **No comments added**

Prepare Another CE Report ERE Home

Access Electronic Requests

Open Requests Page

View / Submit CE Request – Upload Files



Request Details

What's Changed:

Special Instructions:

Documentation:

File Name	Date Added
Request Letter	07/15/2020
Supporting Documentation	07/15/2020
Supporting Documentation	07/15/2020
Supporting Documentation	07/15/2020

Request Response

Was a Consultative Exam performed?

◉ Yes ○ No

Attach and Upload Files

- A maximum of 25 files can be added and all files must total less than 200MB.
- File types accepted: .wpd, .doc, .docx, .jpg, .bmp, .txt, .xls, .xlsx, .pdf, .rtf, .tiff, .tif
- Please do not upload password-protected files because they cannot be processed.

Document Type:

Consultative Examination Report (CE) - 0002

Add Files: Browse...

Additional Information

Comments (Optional):

(4,000 characters maximum)

Characters remaining: 4000

Characters remaining: 4000

Consultative Examination Authorization Agreement

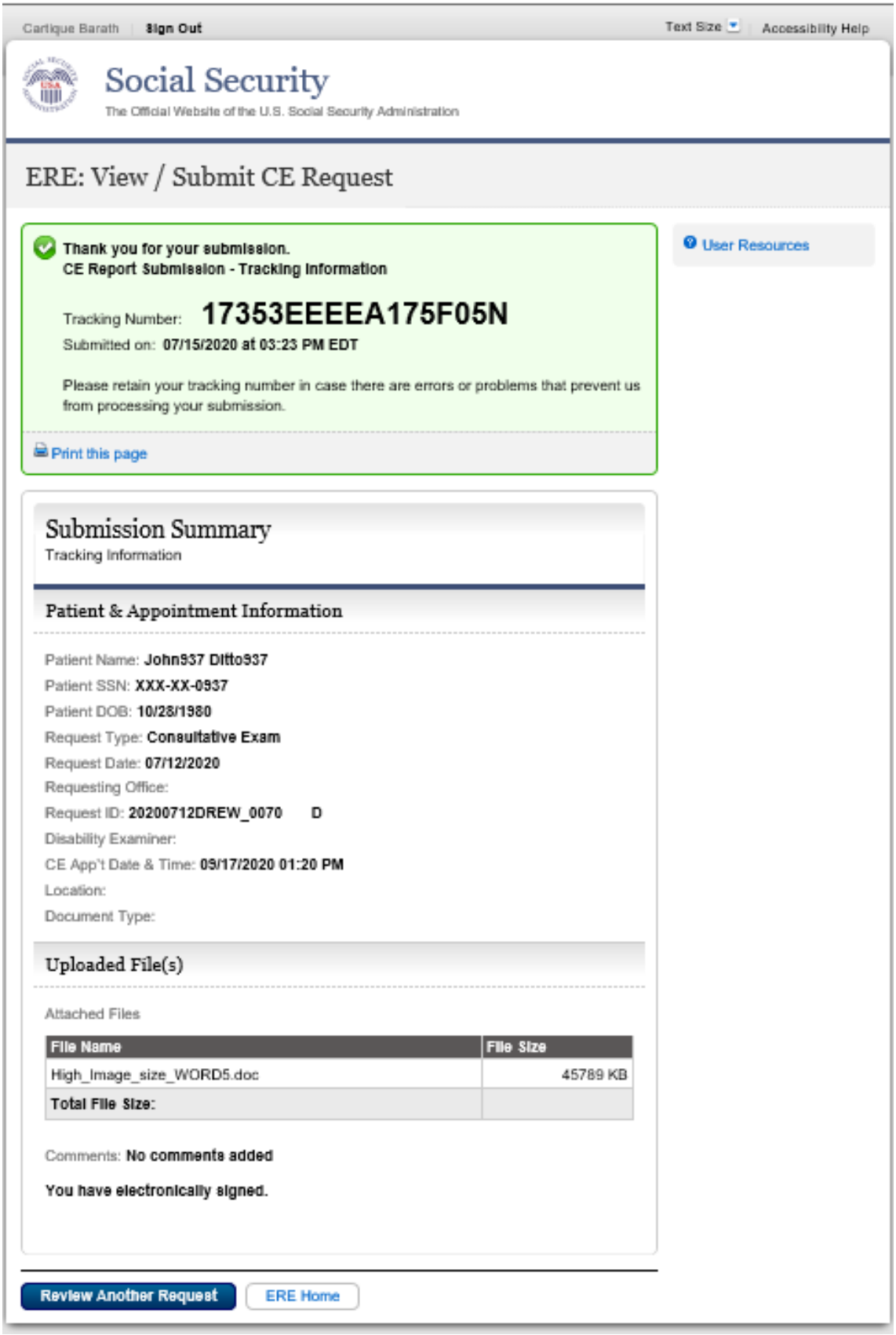
Please read this statement and indicate your understanding by checking the "I have read and agree to the above" checkbox below. When you select "Submit", you will generate an electronic signature and submit your response.

I am certifying, under penalty of perjury, that I have been authorized or contracted by the Disability Determination Services to examine the claimant. I have a valid license and have not been federally excluded. The report is accurate. By checking the "I have read and agree to the above" checkbox below, I am certifying that I personally conducted, or personally participated in conducting, the consultative examination and have electronically signed the report contained within.

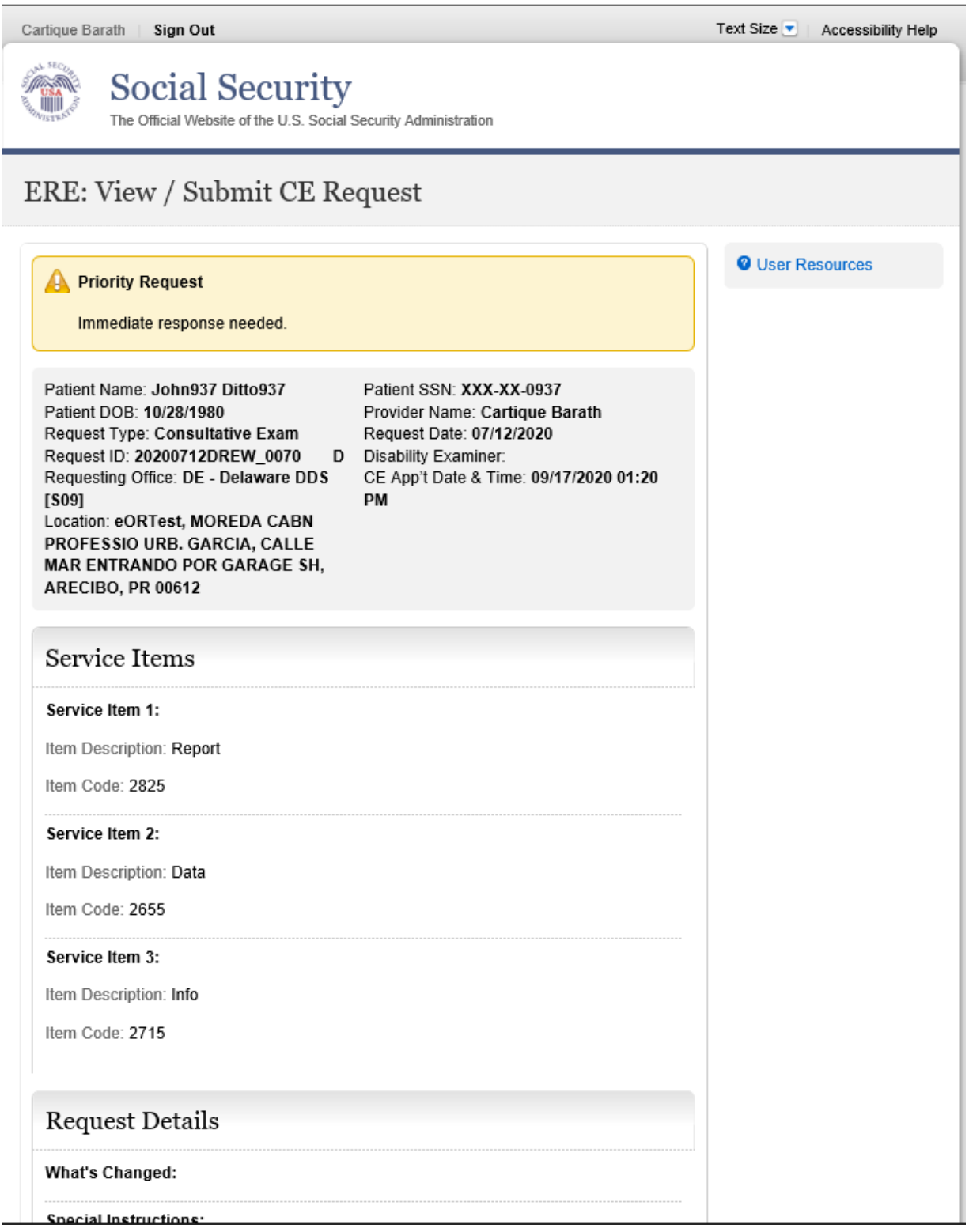
☐ **I have read and agree with the Agreement above.**

Submit | Previous | Cancel

Tracking Page – Upload Files (Site does not do fiscal)



View / Submit CE Request – No Show Response



Request Details

What's Changed:

Special Instructions:

Documentation:

File Name	Date Added
Request Letter	07/15/2020
Supporting Documentation	07/15/2020
Supporting Documentation	07/15/2020
Supporting Documentation	07/15/2020

Request Response

Was a Consultative Exam performed?

○ Yes ◉ No

Add Reason

Reason for No Show Response:

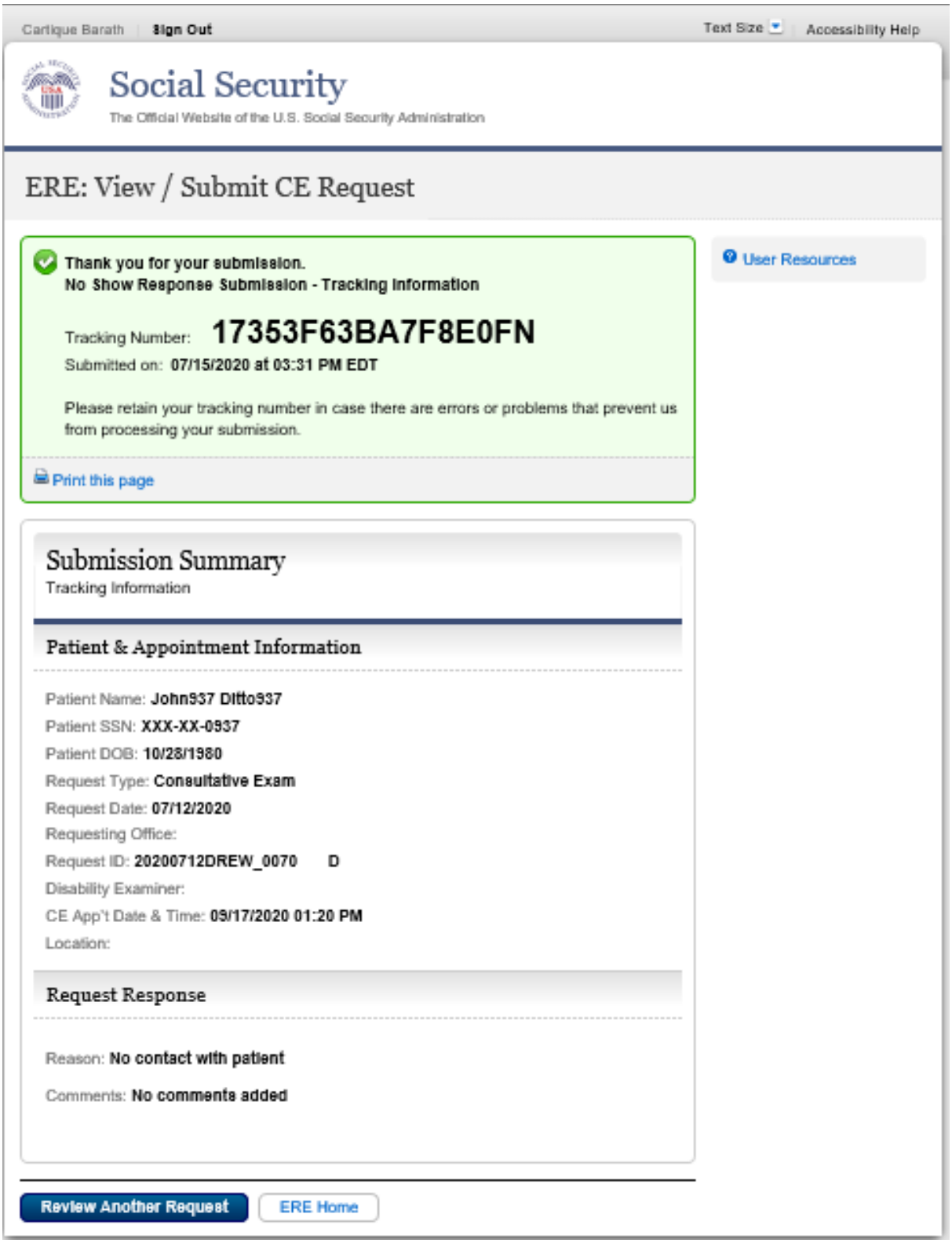
○ No contact with patient
○ Patient cancelled appointment (provide reason if known)
○ Patient showed up for appointment, but could not be evaluated (comments required)
○ Other (comments required)

Comments:
(4,000 characters maximum)

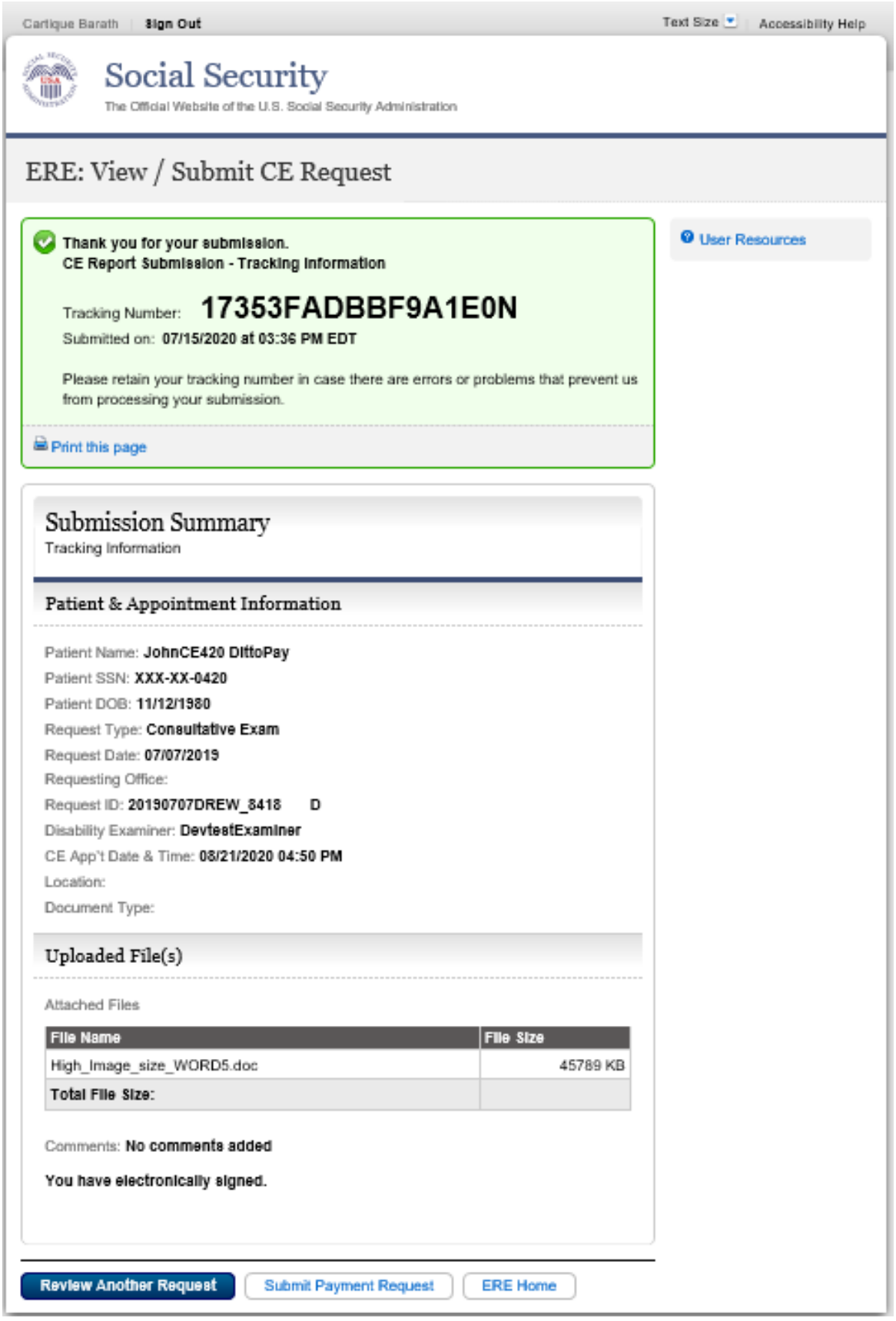
Characters remaining: 4000

Submit Previous Cancel

Tracking Page – No Show Response (Site does not do fiscal)

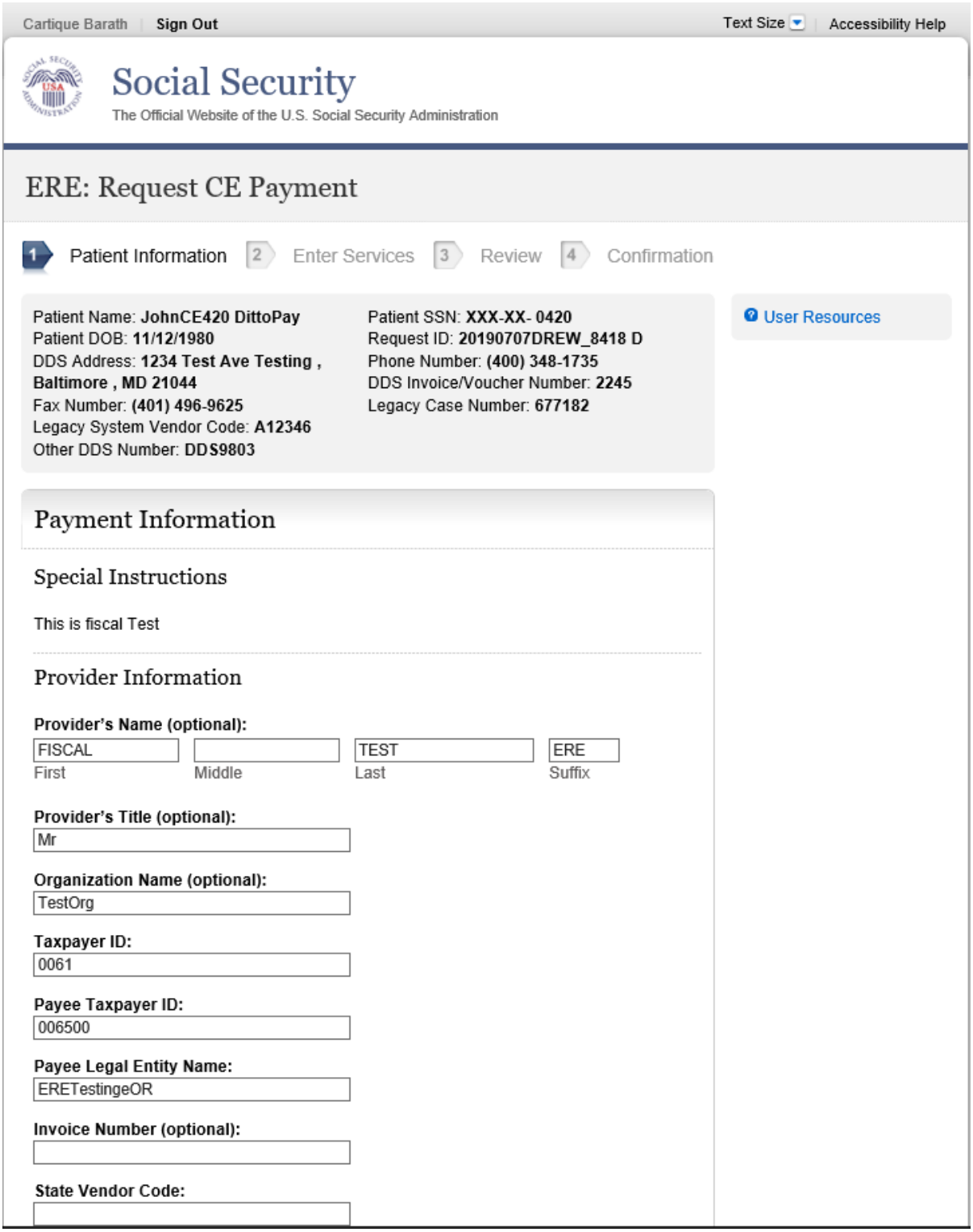


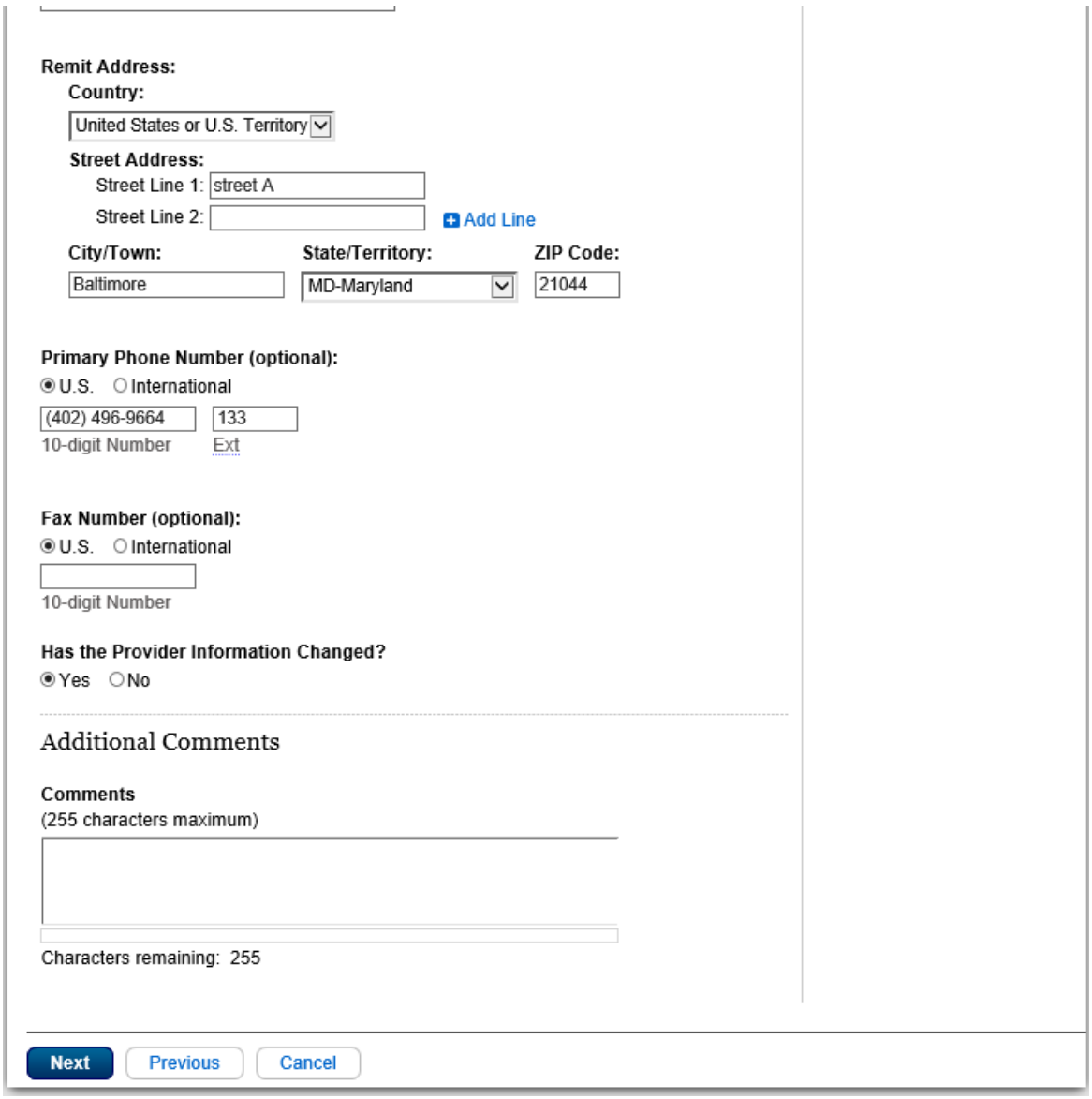
Tracking Page – Upload Files (Site does fiscal)



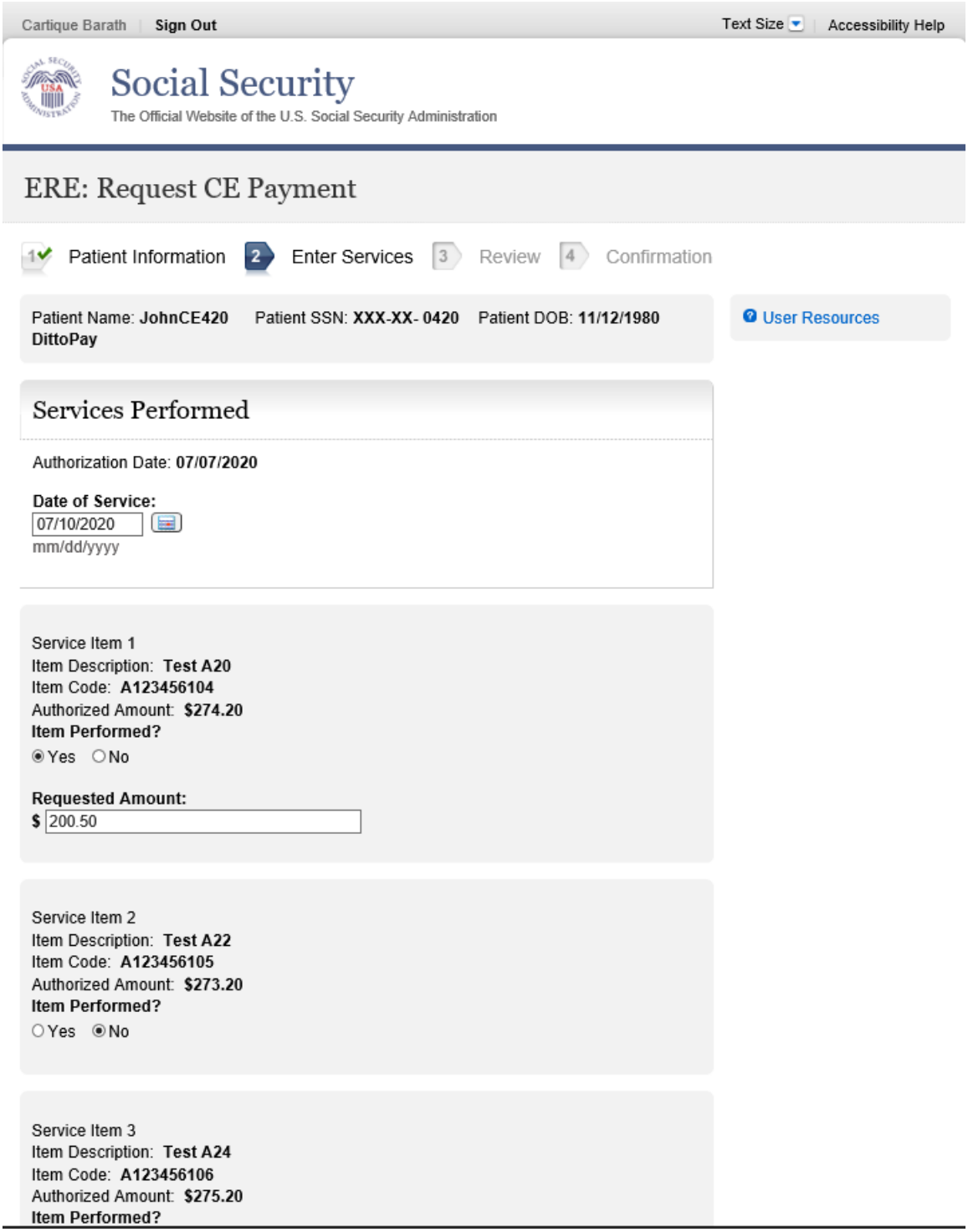
Submit Payment Request for CE

Patient Information




Remit Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1: street A
Street Line 2:
Add Line
City/Town:
State/Territory:
ZIP Code:
Baltimore
MD-Maryland
21044
Primary Phone Number (optional):
U.S. International
(402) 496-9664
133
10-digit Number
Ext
Fax Number (optional):
U.S. International
10-digit Number
Has the Provider Information Changed?
Yes No
Additional Comments
Comments
(255 characters maximum)
Characters remaining: 255
Next
Previous
Cancel

Services Performed



Service Item 3
Item Description: **Test A24**
Item Code: **A123456106**
Authorized Amount: **$275.20**
Item Performed?
◉ Yes ○ No

Requested Amount:
$ 125.10

Additional Service Item 1

Item Description:
(255 characters maximum)
testing for OMB package

Item Code (optional):
OMB

Requested Amount:
$ 100.25

Authorized By:
Kal Penn

When Authorized:
July 14, 2020
If the exact date is unknown, please provide your best estimate

Delete

Add Additional Service

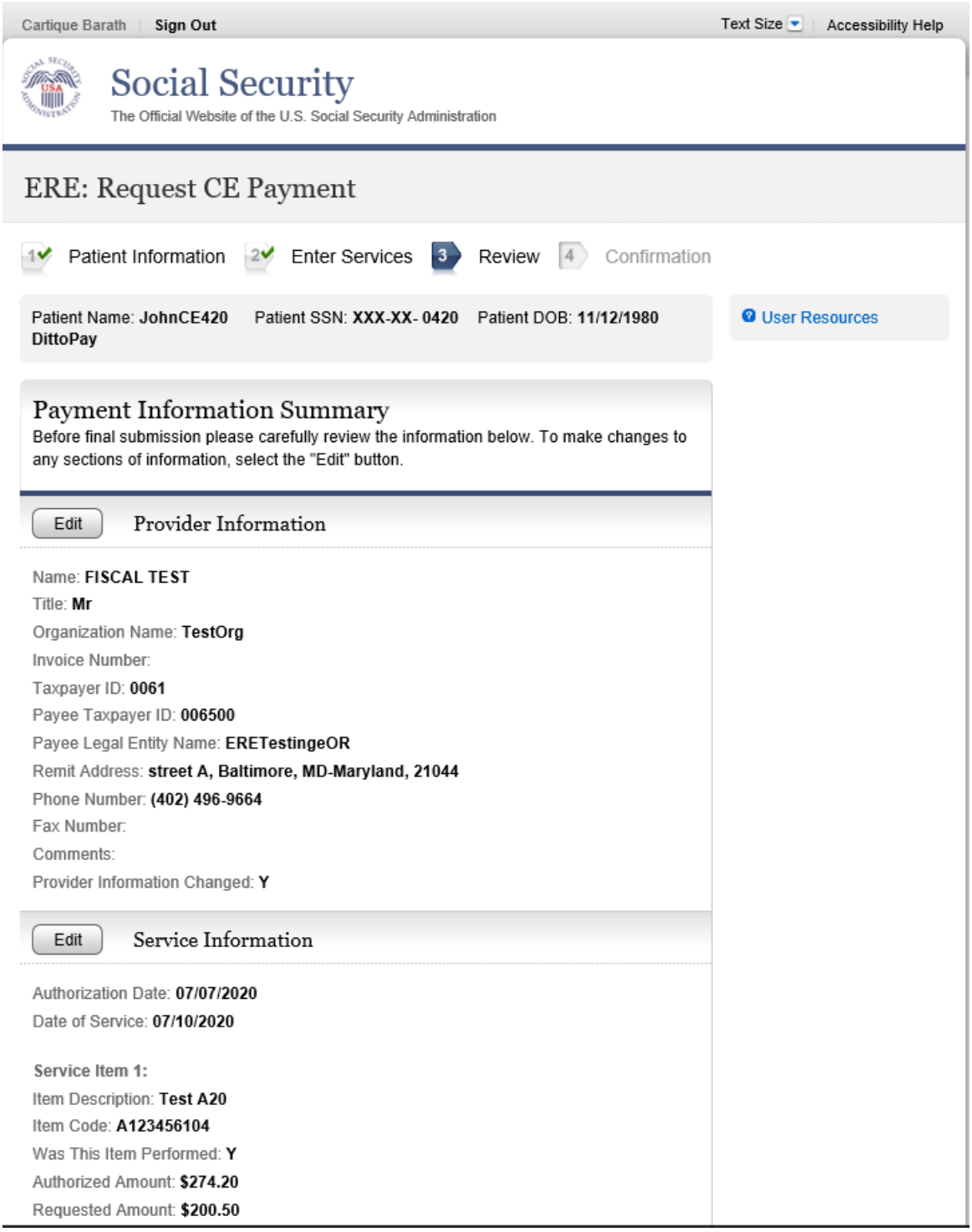
Services Performed Total: **$325.60**

Additional Requested Total: **$100.25**

Total Payment Requested: **$425.85**

Next Previous Cancel

Review – Upload Invoices



Date of Service: **07/10/2020**

Service Item 1:
Item Description: **Test A20**
Item Code: **A123456104**
Was This Item Performed: **Y**
Authorized Amount: **$274.20**
Requested Amount: **$200.50**

Service Item 2:
Item Description: **Test A22**
Item Code: **A123456105**
Was This Item Performed: **N**
Authorized Amount: **$273.20**
Requested Amount: **$**

Service Item 3:
Item Description: **Test A24**
Item Code: **A123456106**
Was This Item Performed: **Y**
Authorized Amount: **$275.20**
Requested Amount: **$125.10**

Additional Service Item 1:
Item Description: **testing for OMB package**
Item Code: **OMB**
Requested Amount: **$100.25**
Authorized By: **Kal Penn**
When Authorized: **July 14, 2020**

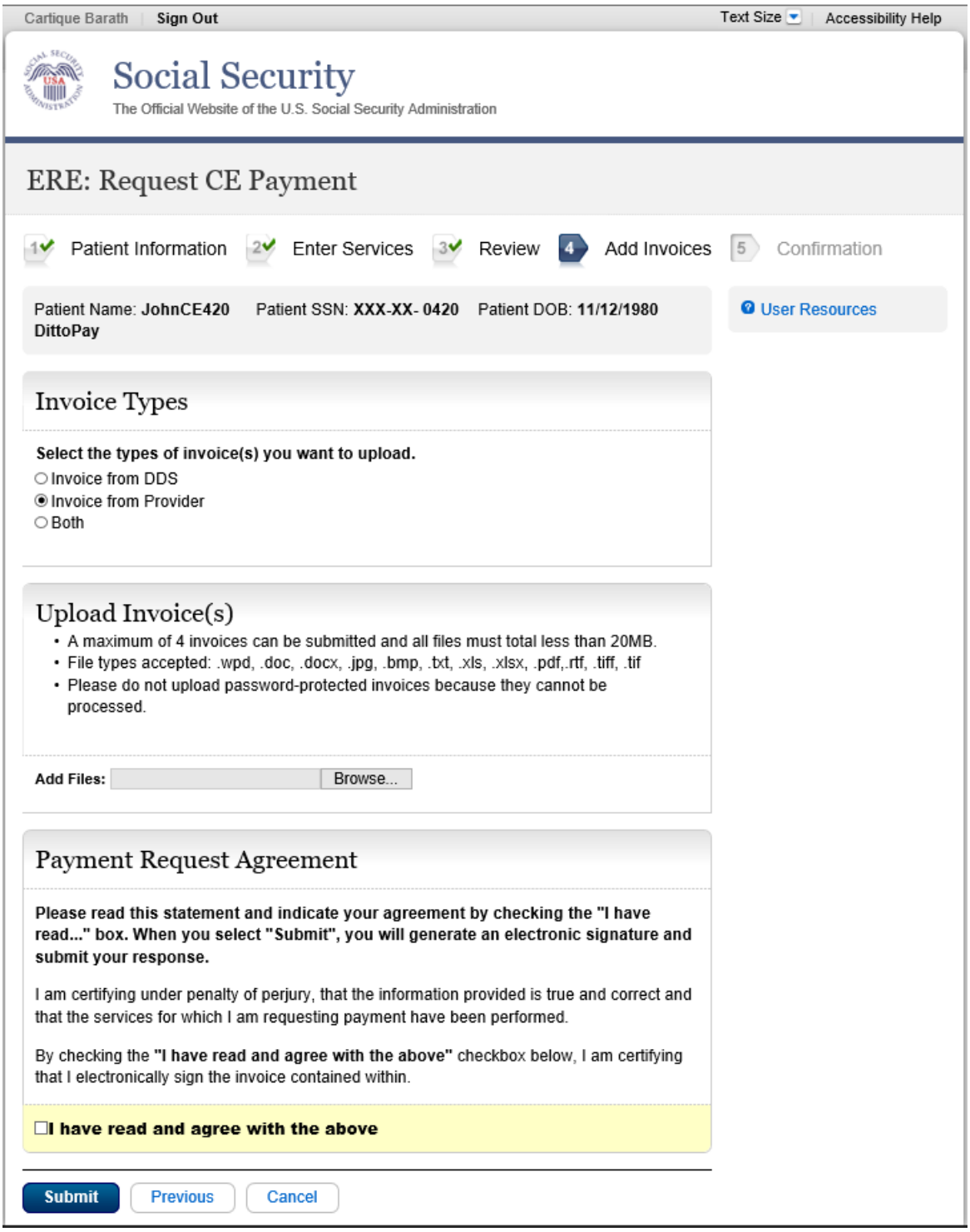
Additional Requested Total: **100.25**
Services Performed Total: **325.60**
Total Payment Requested: **425.85**

Upload Invoices

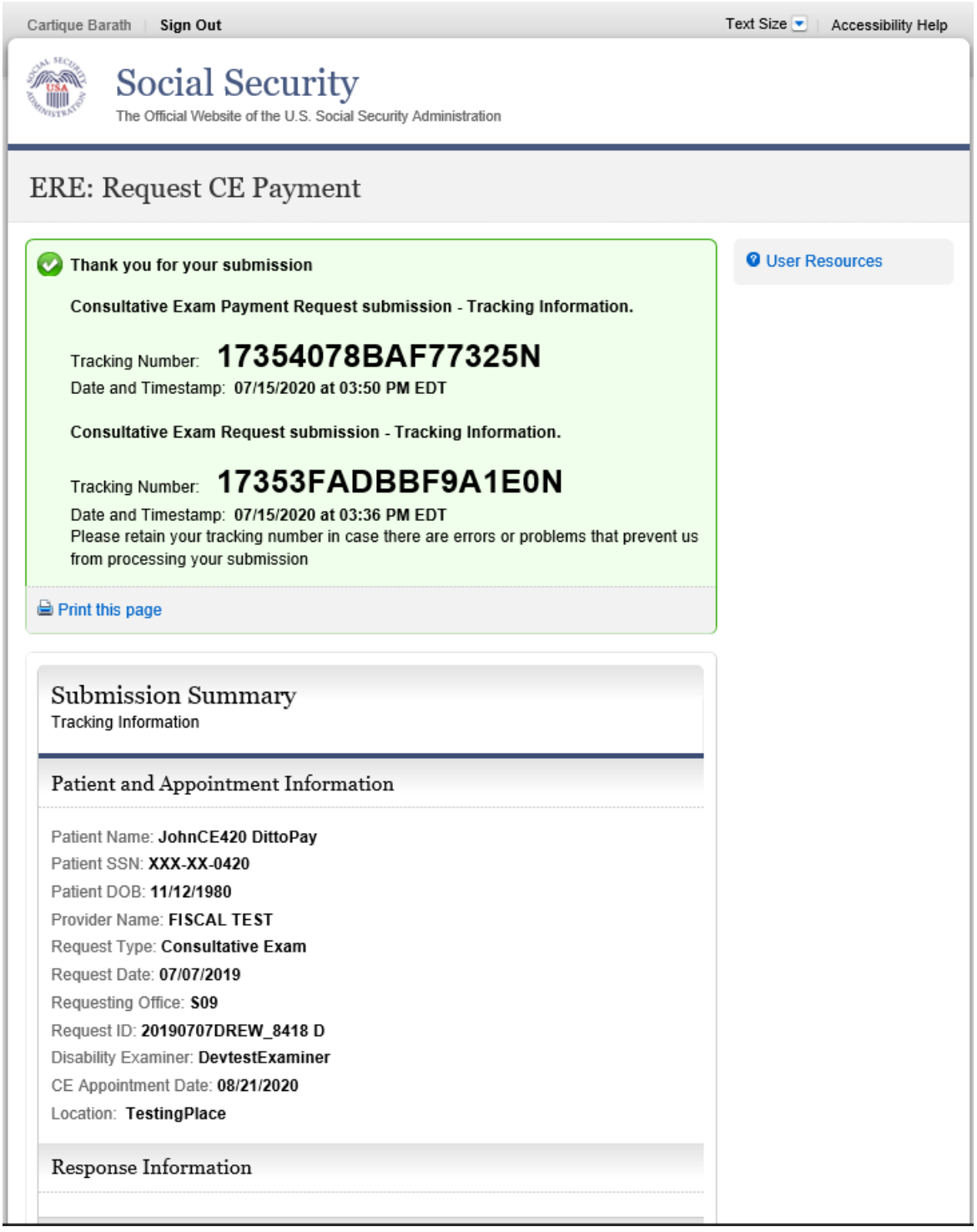
Do you have invoices to upload?
◉ Yes ○ No

Next | Previous | Cancel

Add Invoices



Tracking Page – Uploaded Invoices



Response Information

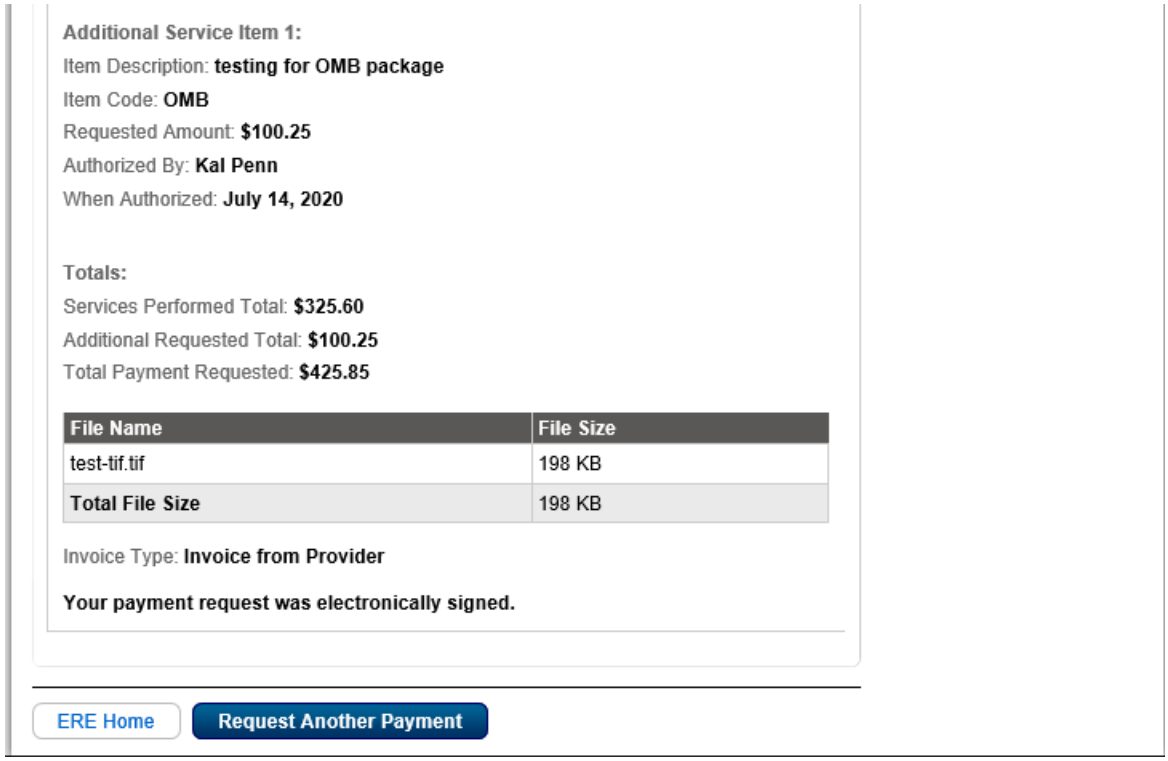
Payment Request Information

DDS Invoice/Voucher Number: **2245**
Legacy Case Number: **677182**
Other DDS Number: **DDS9803**
Provider Name: **FISCAL TEST**
Provider Title: **Mr**
Organization Name: **TestOrg**
Invoice Number:
Taxpayer ID: **0061**
Payee Taxpayer ID: **006500**
Payee Legal Entity Name: **ERETestingeOR**
State Vendor Code: **1234MD234SH**
Remit Address: **street A, Baltimore, MD-Maryland, 21044**
Phone Number: **(402) 496-9664 ext. 133**
Fax Number:
Provider Information changed: **Yes**
Date of Service: **07/10/2020**

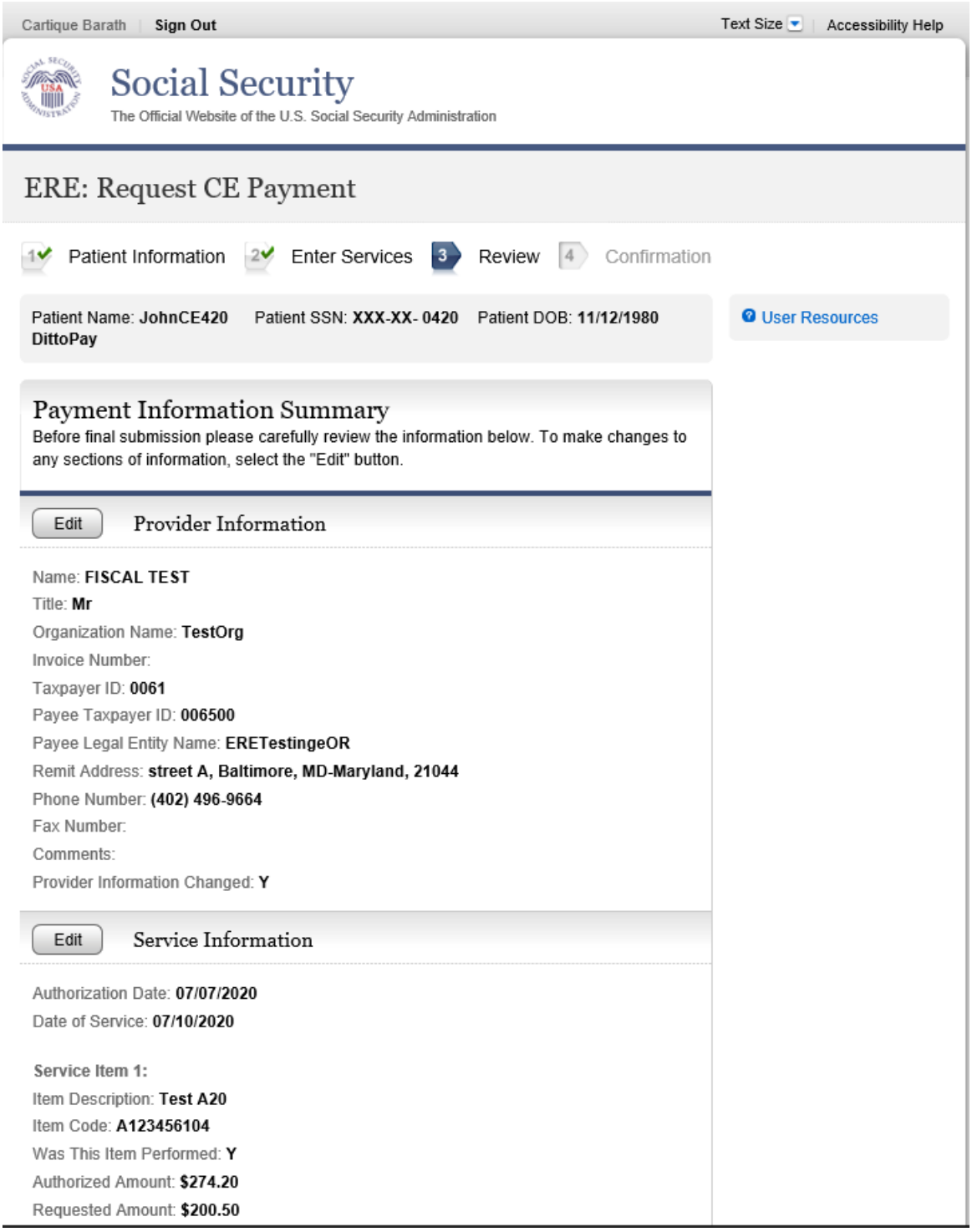
Service Item 1:
Item Description: **Test A20**
Item Code: **A123456104**
Was This Item Performed: **Y**
Authorized Amount: **$274.20**
Requested Amount: **$200.50**

Service Item 2:
Item Description: **Test A22**
Item Code: **A123456105**
Was This Item Performed: **N**
Authorized Amount: **$273.20**
Requested Amount: **$**

Service Item 3:
Item Description: **Test A24**
Item Code: **A123456106**
Was This Item Performed: **Y**
Authorized Amount: **$275.20**
Requested Amount: **$125.10**


Additional Service Item 1:
Item Description: testing for OMB package
Item Code: OMB
Requested Amount: $100.25
Authorized By: Kal Penn
When Authorized: July 14, 2020
Totals:
Services Performed Total: $325.60
Additional Requested Total: $100.25
Total Payment Requested: $425.85
File Name
File Size
test-tif.tif
198 KB
Total File Size
198 KB
Invoice Type: Invoice from Provider
Your payment request was electronically signed.
ERE Home
Request Another Payment

Review – No Invoices to Upload



Was This Item Performed: **N**
Authorized Amount: **$273.20**
Requested Amount: **$**

Service Item 3:
Item Description: **Test A24**
Item Code: **A123456106**
Was This Item Performed: **Y**
Authorized Amount: **$275.20**
Requested Amount: **$125.10**

Additional Service Item 1:
Item Description: **testing for OMB package**
Item Code: **OMB**
Requested Amount: **$100.25**
Authorized By: **Kal Penn**
When Authorized: **July 14, 2020**

Additional Requested Total: **100.25**
Services Performed Total: **325.60**
Total Payment Requested: **425.85**

Upload Invoices

Do you have invoices to upload?
○ Yes ◉ No

Payment Request Agreement

Please read this statement and indicate your agreement by checking the "I have read..." box. When you select "Submit", you will generate an electronic signature and submit your response.

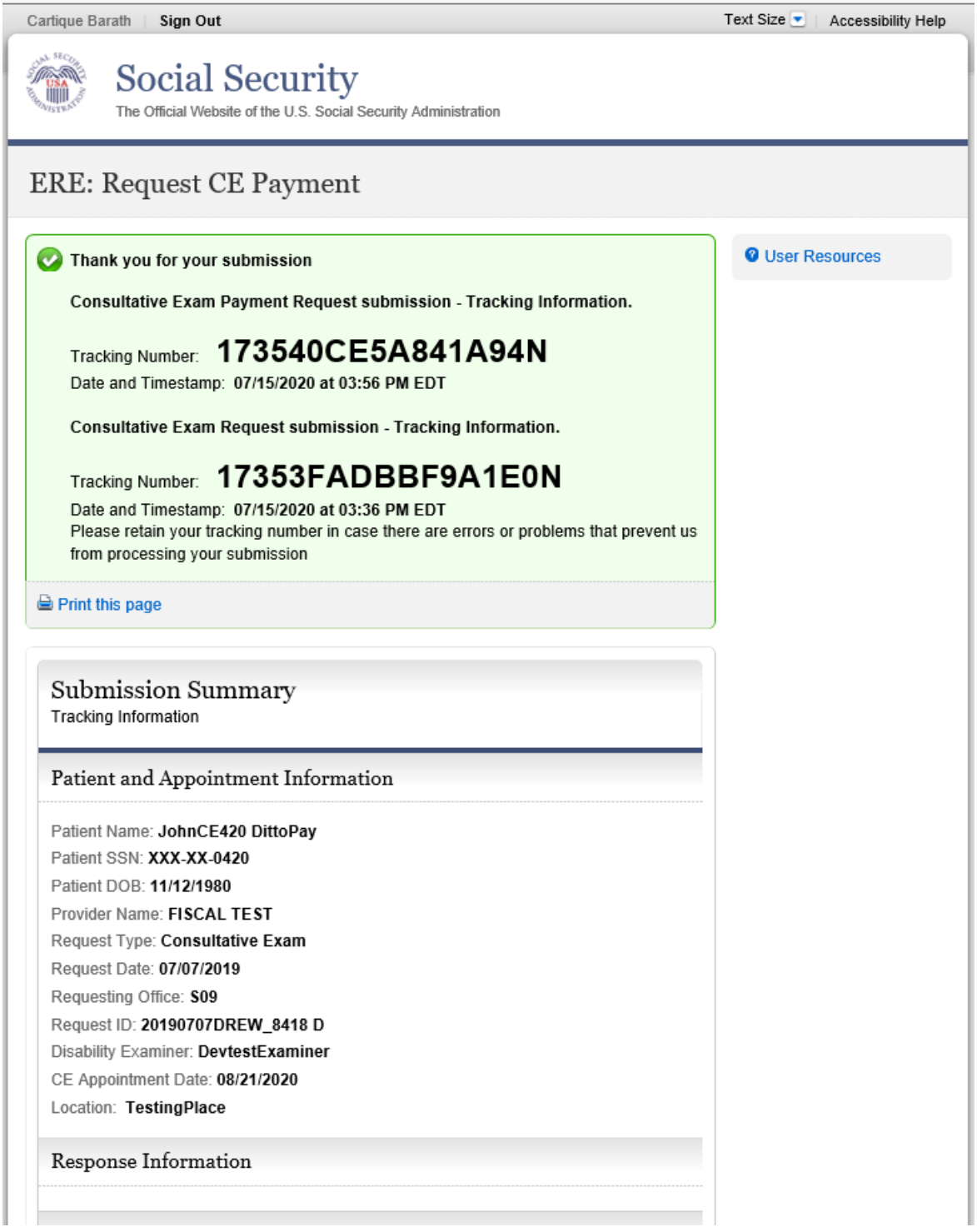
I am certifying under penalty of perjury, that the information provided is ture and correct and that the services for which I am requesting payment have been performed.

By checking the "**I have read and agree with the above**" checkbox below, I am certifying that I electronically sign the invoice contained within.

☐ **I have read and agree with the above**

Submit | Previous | Cancel

Tracking Page – No Invoices Uploaded



Response Information

Payment Request Information

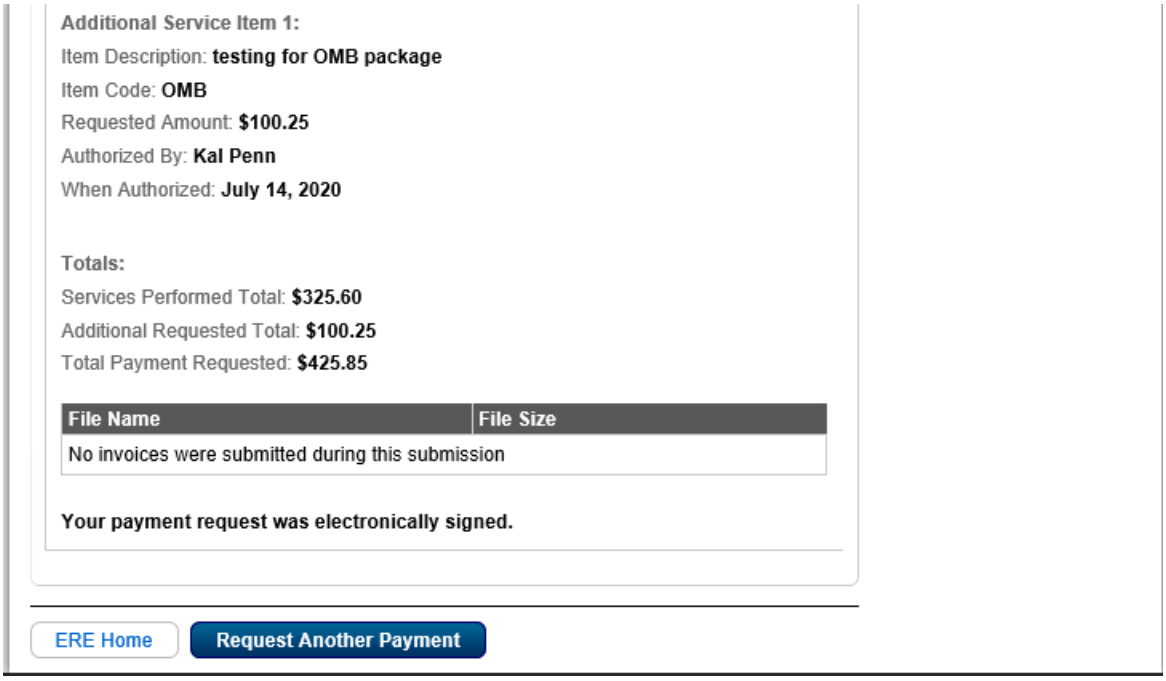
DDS Invoice/Voucher Number: **2245**
Legacy Case Number: **677182**
Other DDS Number: **DDS9803**
Provider Name: **FISCAL TEST**
Provider Title: **Mr**
Organization Name: **TestOrg**
Invoice Number:
Taxpayer ID: **0061**
Payee Taxpayer ID: **006500**
Payee Legal Entity Name: **ERETestingeOR**
State Vendor Code: **1234MD234SH**
Remit Address: **street A, Baltimore, MD-Maryland, 21044**
Phone Number: **(402) 496-9664 ext. 133**
Fax Number:
Provider Information changed: **Yes**
Date of Service: **07/10/2020**

Service Item 1:
Item Description: **Test A20**
Item Code: **A123456104**
Was This Item Performed: **Y**
Authorized Amount: **$274.20**
Requested Amount: **$200.50**

Service Item 2:
Item Description: **Test A22**
Item Code: **A123456105**
Was This Item Performed: **N**
Authorized Amount: **$273.20**
Requested Amount: **$**

Service Item 3:
Item Description: **Test A24**
Item Code: **A123456106**
Was This Item Performed: **Y**
Authorized Amount: **$275.20**
Requested Amount: **$125.10**

Additional Service Item 1:



Additional Service Item 1:

Item Description: **testing for OMB package**

Item Code: **OMB**

Requested Amount: **$100.25**

Authorized By: **Kal Penn**

When Authorized: **July 14, 2020**

Totals:

Services Performed Total: **$325.60**

Additional Requested Total: **$100.25**

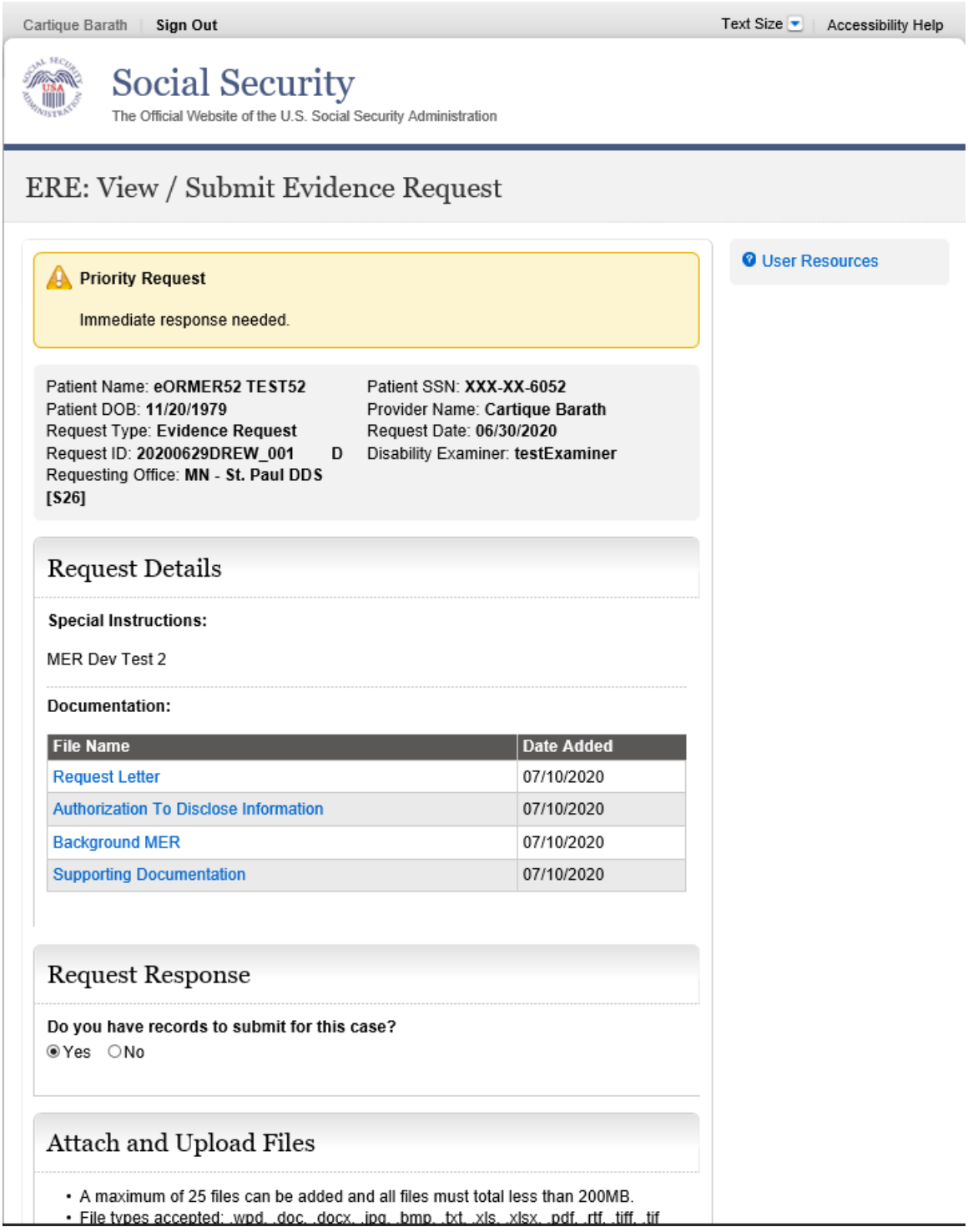
Total Payment Requested: **$425.85**

File Name	File Size
No invoices were submitted during this submission	

Your payment request was electronically signed.

ERE Home | Request Another Payment

View / Submit Evidence Request – Upload Records



- Please do not upload password-protected files because they cannot be processed.

Document Type:

Medical Evidence of Record (MER) - 0001

Add Files: Browse...

Additional Information

Comments (Optional):
(4,000 characters maximum)

Characters remaining: 4000

Additional Examination or Test (Optional)

Is the provider willing to provide an additional examination or test?

○ Yes ○ No

Electronic Signature Agreement (Optional)

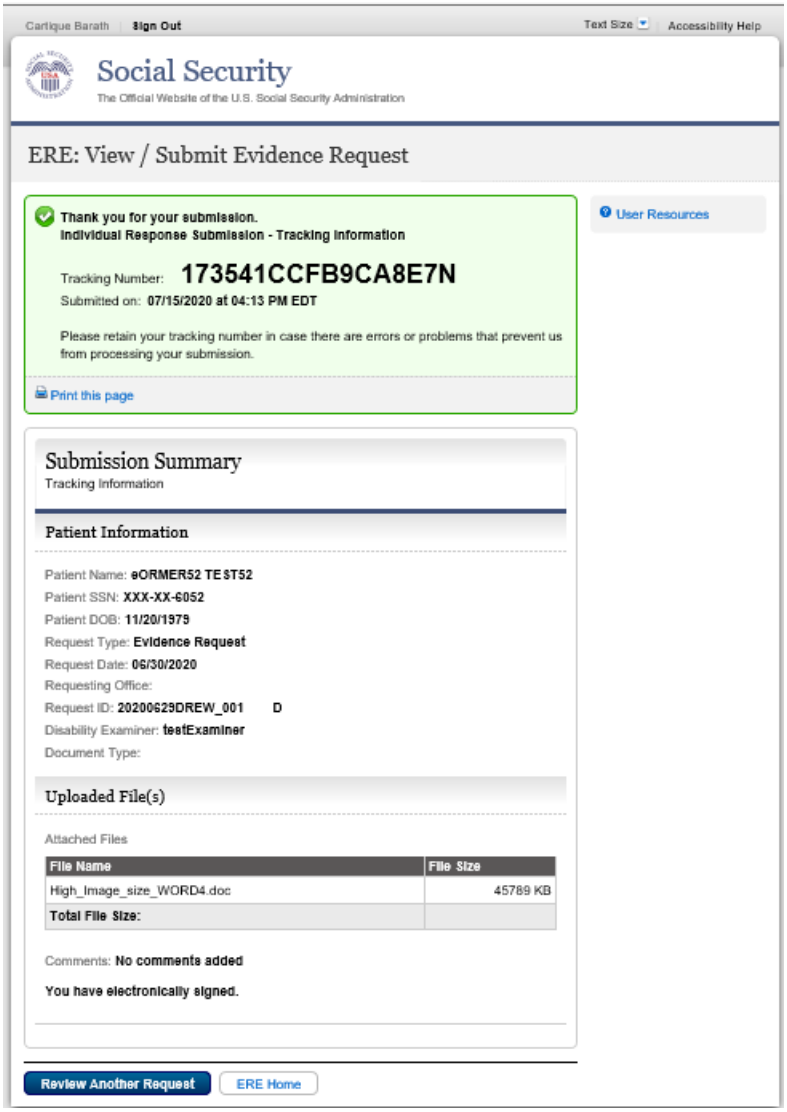
If you wish to generate an electronic signature, please read this statement and indicate your understanding by checking the "I have read and agree to the above" checkbox below. When you select "Submit", you will generate an electronic signature and submit your response.

By checking the "I have read and to the above" checkbox below, I am certifying that I am the author of the uploaded document(s). The information I have uploaded is accurate and I am certifying that I have electronically signed the document(s) contained within.

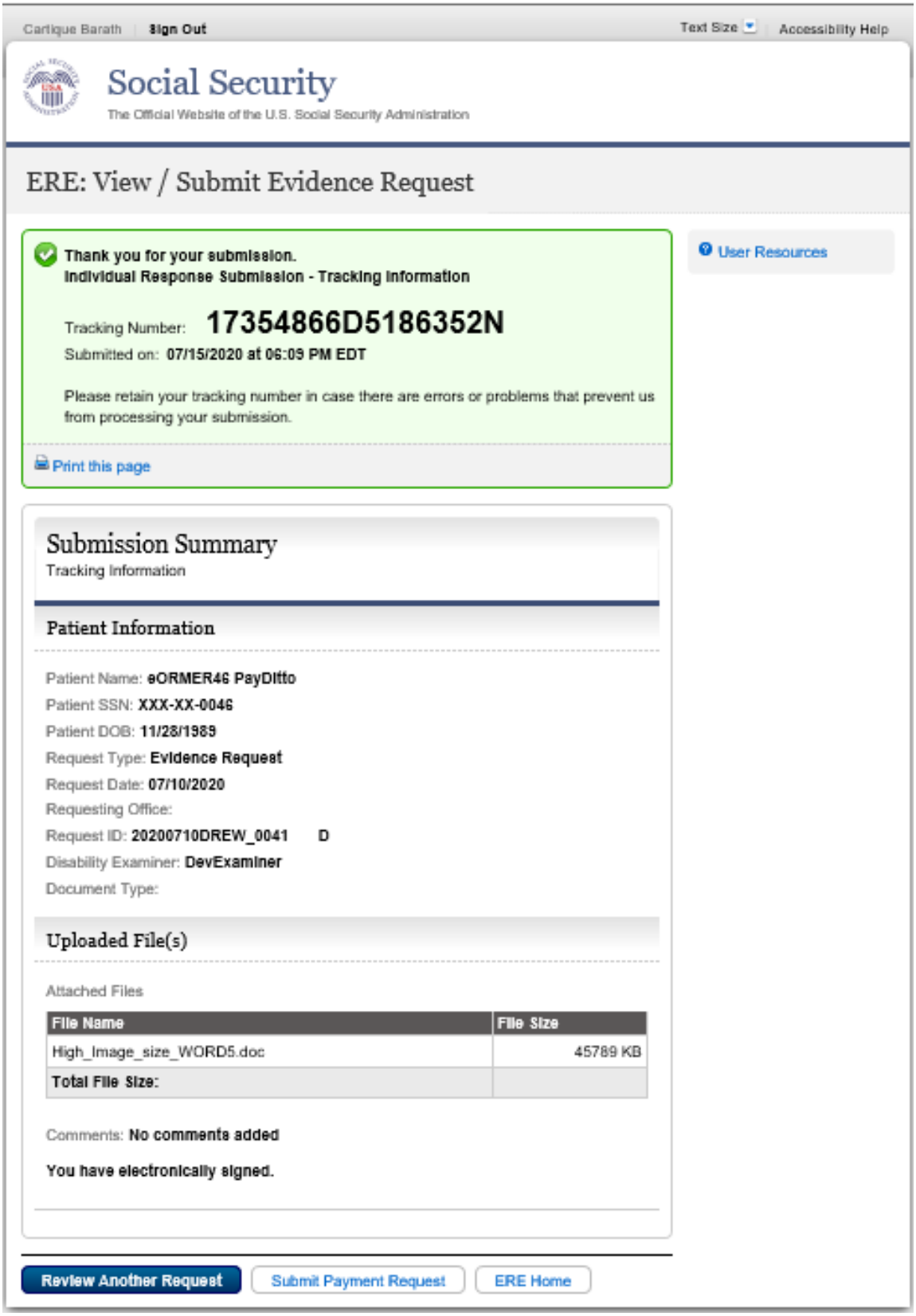
☐ **I have read and agree with the Agreement above.**

Submit Previous Cancel

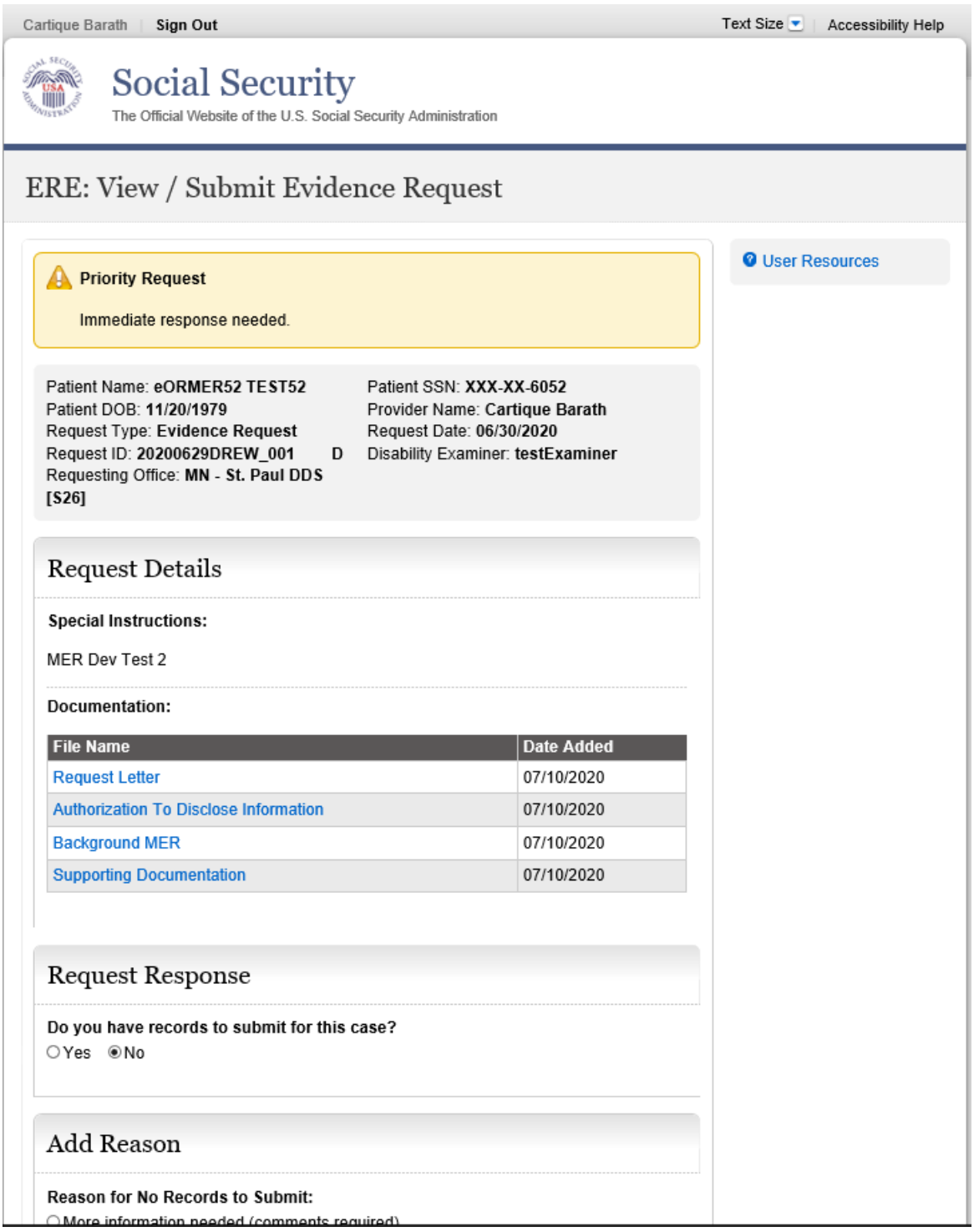
Tracking Page – Upload Records (Site does not do fiscal)

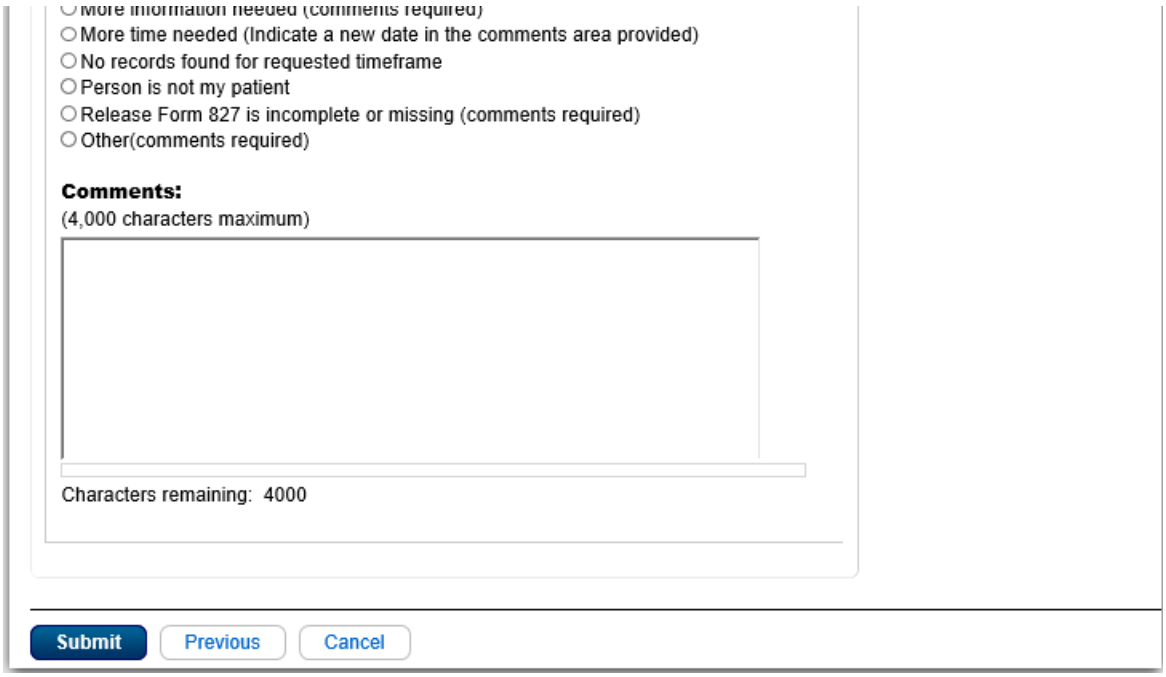


Tracking Page – Upload Records (Site does fiscal)

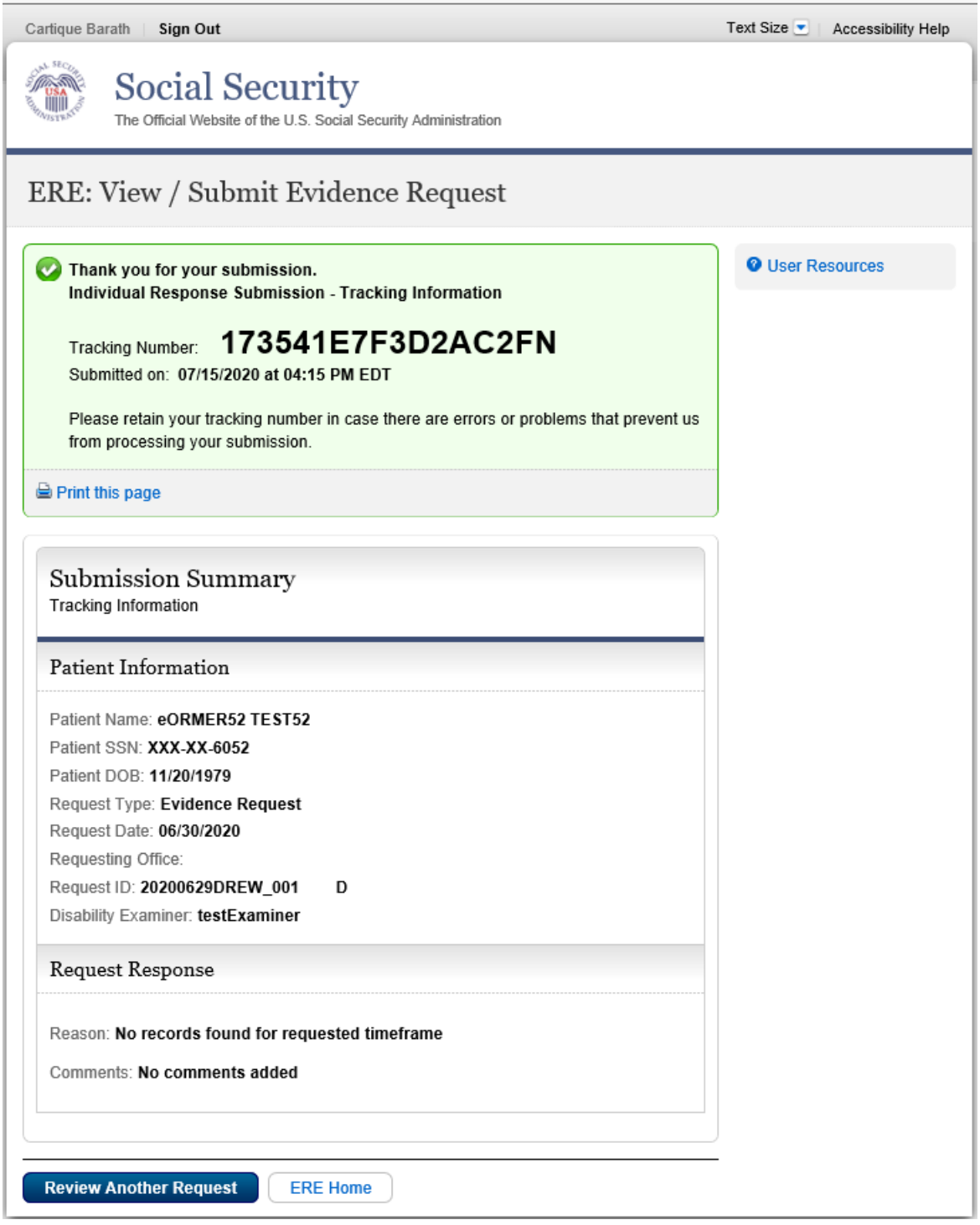


View / Submit Evidence Request – No Records

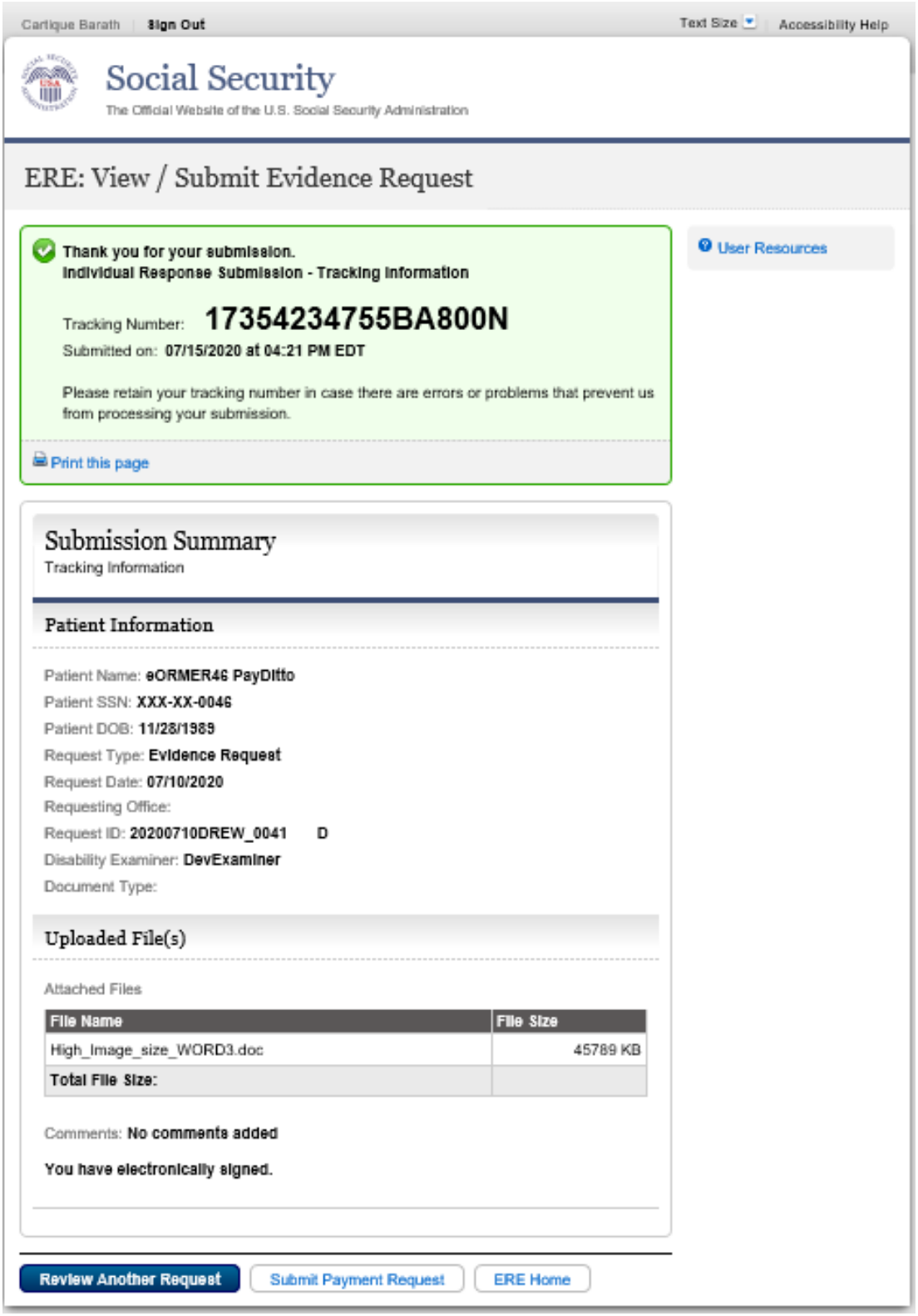



More information needed (comments required)
More time needed (Indicate a new date in the comments area provided)
No records found for requested timeframe
Person is not my patient
Release Form 827 is incomplete or missing (comments required)
Other(comments required)
Comments:
(4,000 characters maximum)
Characters remaining: 4000
Submit
Previous
Cancel

Tracking Page – No Records (Site does not fiscal)

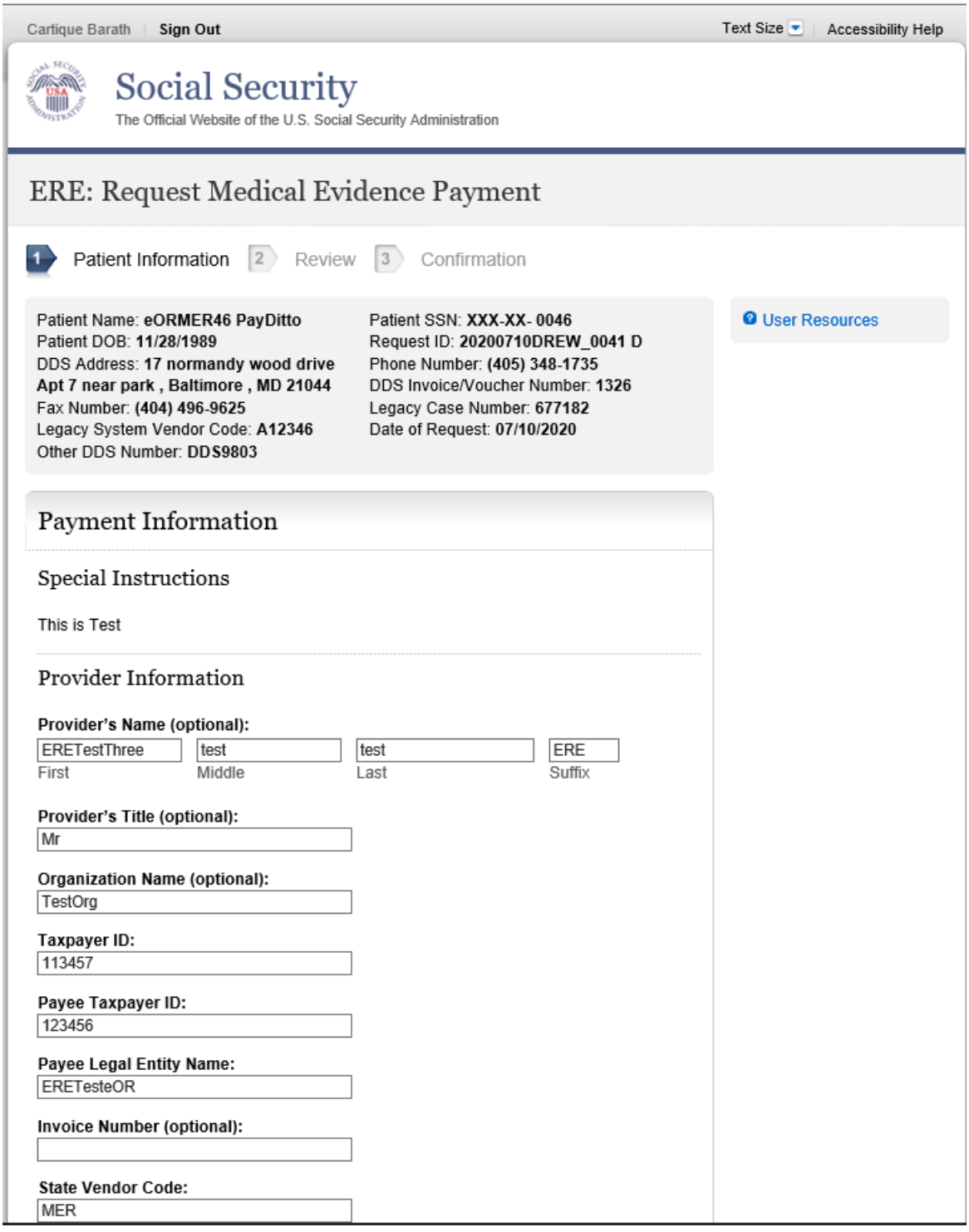


Tracking Page – No Records (Site does fiscal)



Submit Payment Requests for MER

Patient Information



Remit Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1: 11 Woods

Street Line 2: 15 testing palace

Street Line 3: test area

Street Line 4: test4

City/Town: Westmead

State/Territory: MD-Maryland

ZIP Code: 21044

Primary Phone Number (optional):

◉ U.S. ○ International

(404) 496-9664 (10-digit Number) 125 (Ext)

Fax Number (optional):

◉ U.S. ○ International

10-digit Number

Has the Provider Information Changed?

○ Yes ○ No

Payment Information

Payment Requested Amount:

Page Count (Optional):

Were records photocopied?

○ Yes ○ No

Additional Comments

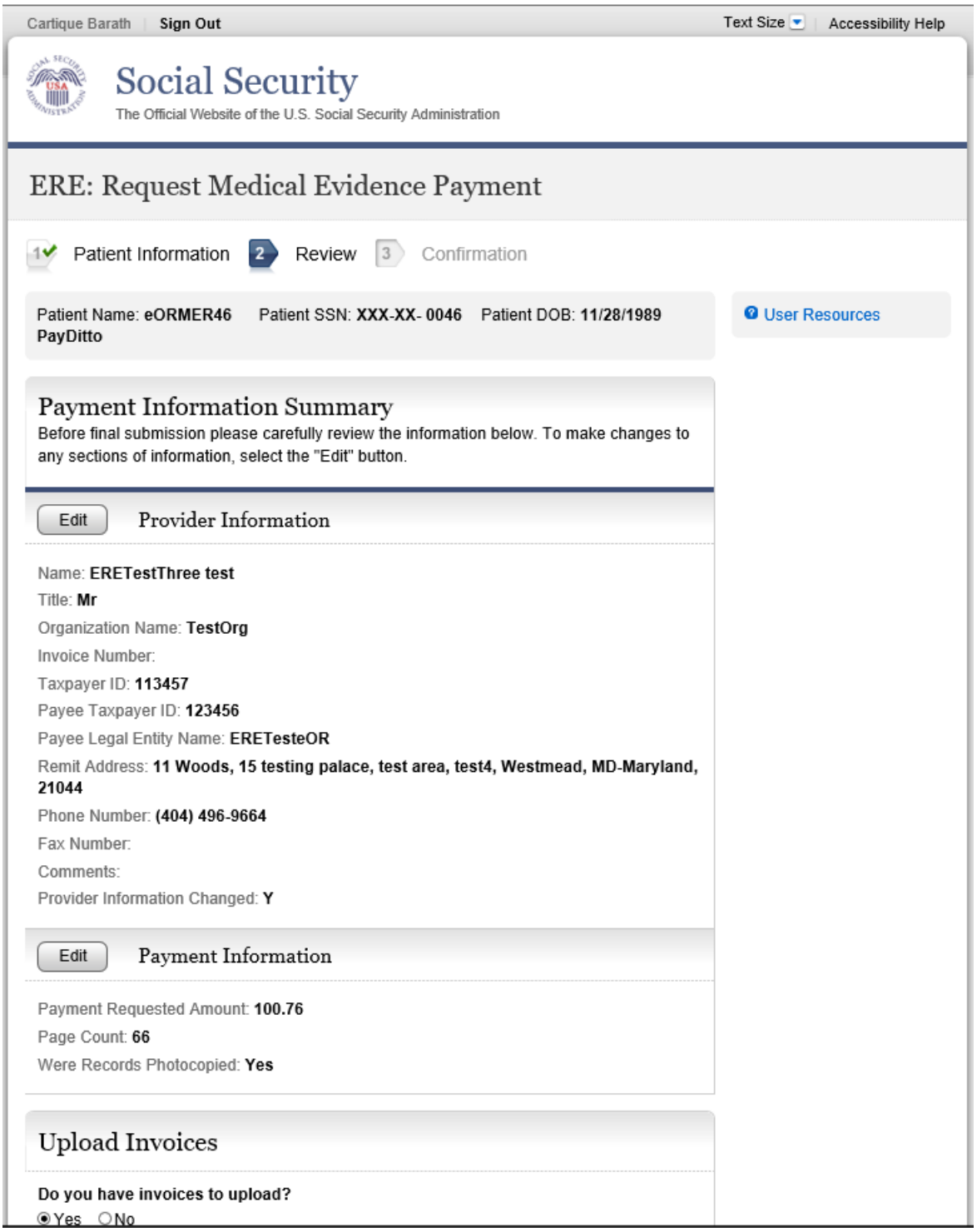
Comments

(255 characters maximum)

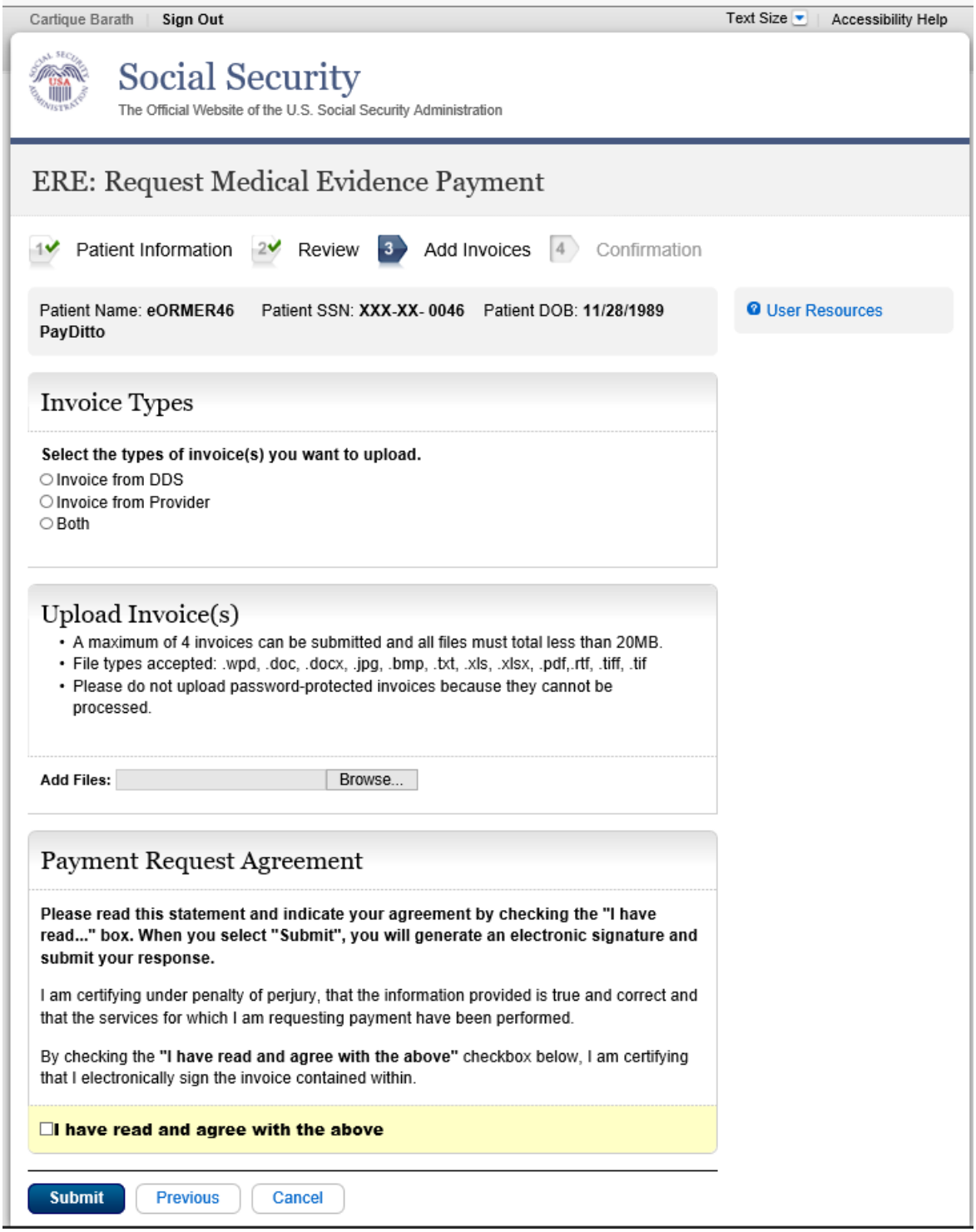
Characters remaining: 255

Next | Previous | Cancel

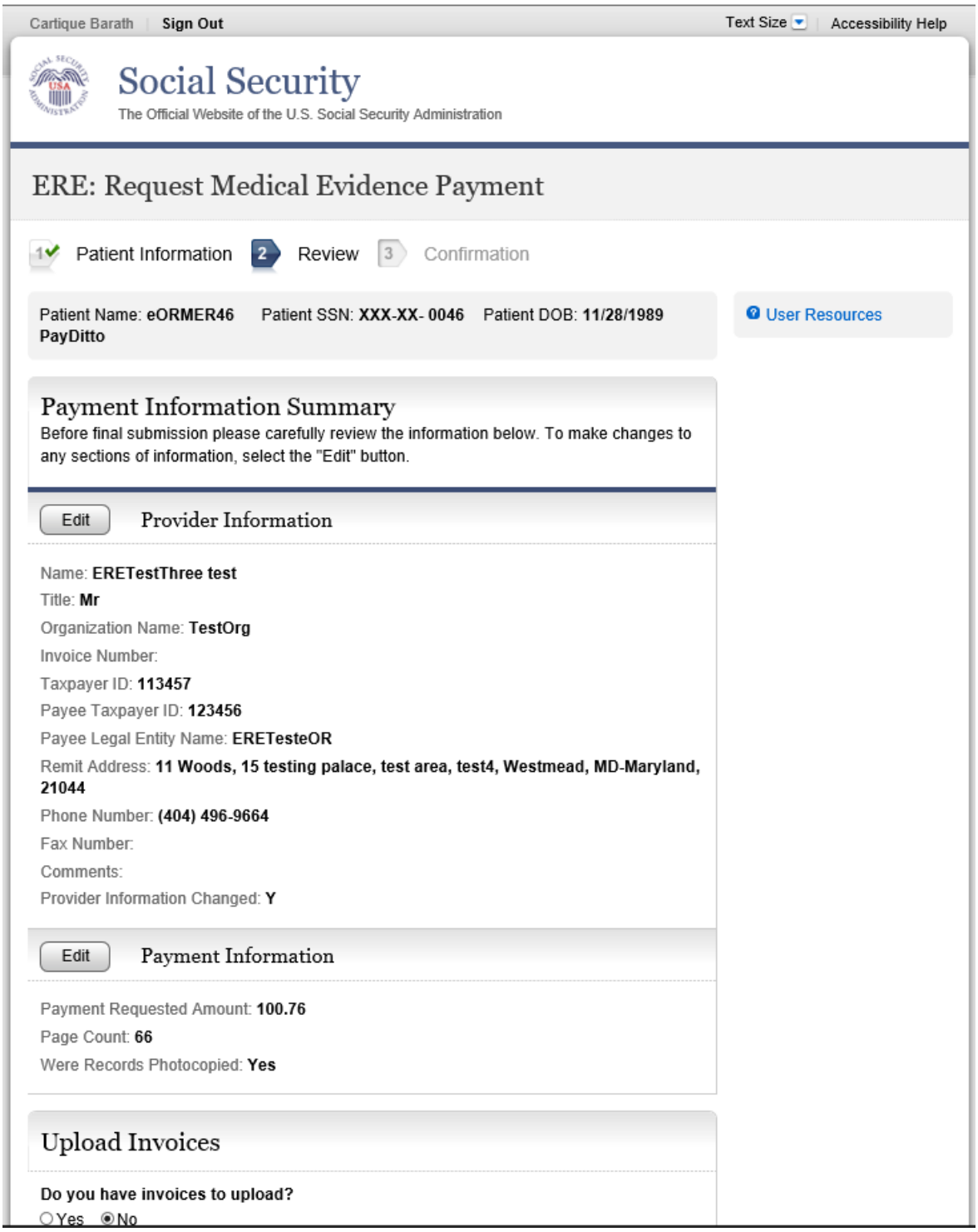
Review – Upload Invoices

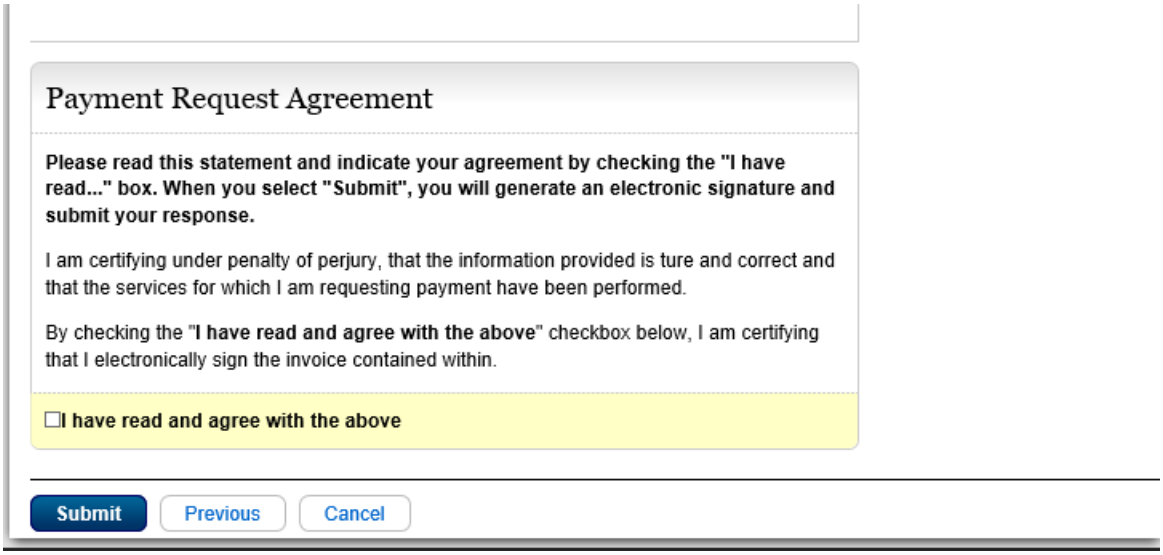


Upload Invoices

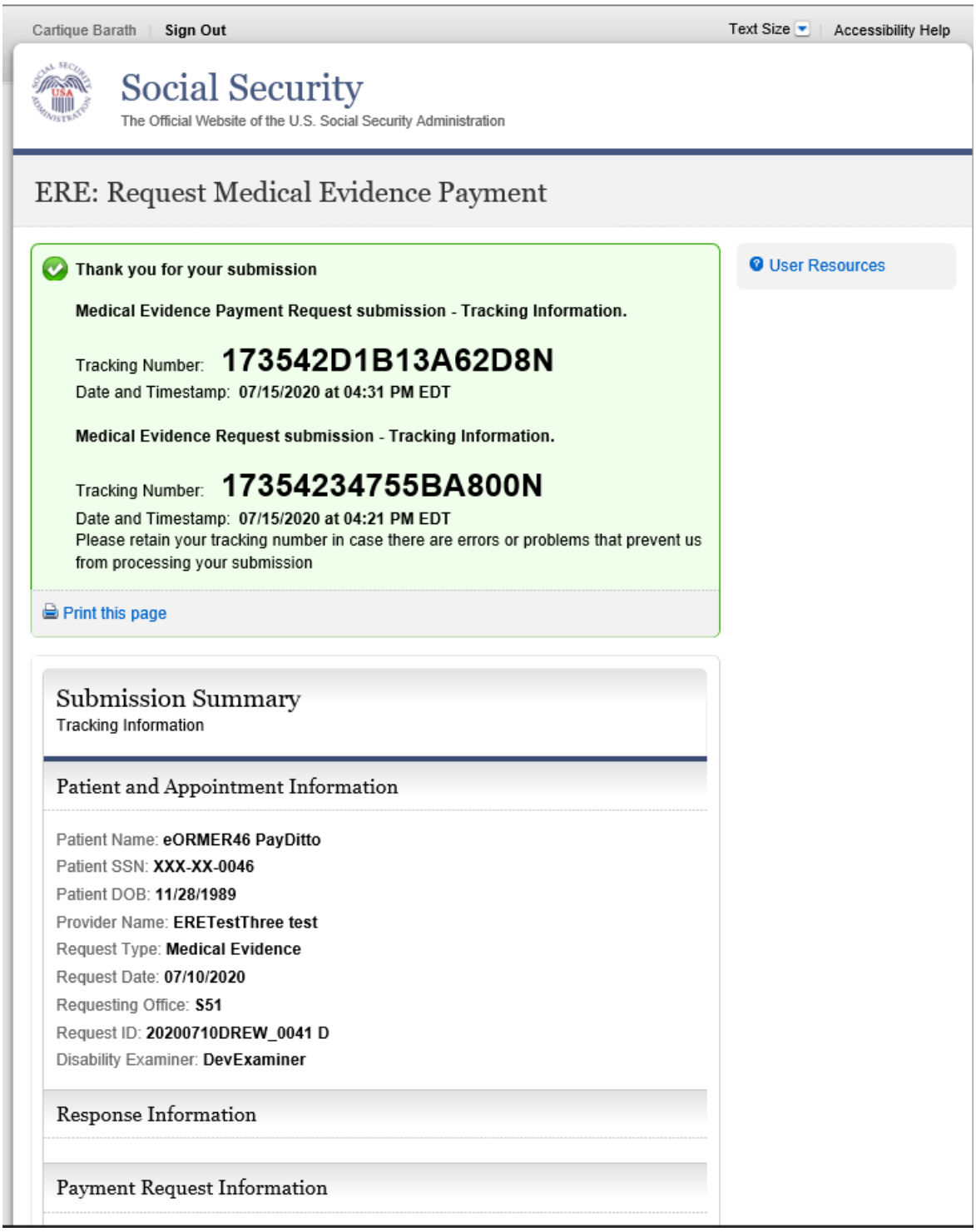


Review – No Invoices




Payment Request Agreement
Please read this statement and indicate your agreement by checking the "I have read..." box. When you select "Submit", you will generate an electronic signature and submit your response.
I am certifying under penalty of perjury, that the information provided is ture and correct and that the services for which I am requesting payment have been performed.
By checking the "I have read and agree with the above" checkbox below, I am certifying that I electronically sign the invoice contained within.
I have read and agree with the above
Submit
Previous
Cancel

Upload Invoices Tracking Page



Payment Request Information

DDS Invoice/Voucher Number: **1326**
Legacy Case Number: **677182**
Other DDS Number: **DDS9803**
Provider Name: **ERETestThree test**
Provider Title: **Mr**
Organization Name: **TestOrg**
Invoice Number:
Taxpayer ID: **113457**
Payee Taxpayer ID: **123456**
Payee Legal Entity Name: **ERETesteOR**
State Vendor Code: **MER**
Remit Address: **11 Woods, 15 testing palace, test area, test4, Westmead, MD-Maryland, 21044**
Phone Number: **(404) 496-9664 ext. 125**
Fax Number:
Provider Information changed: **Yes**
Payment Requested Amount: **$100.76**

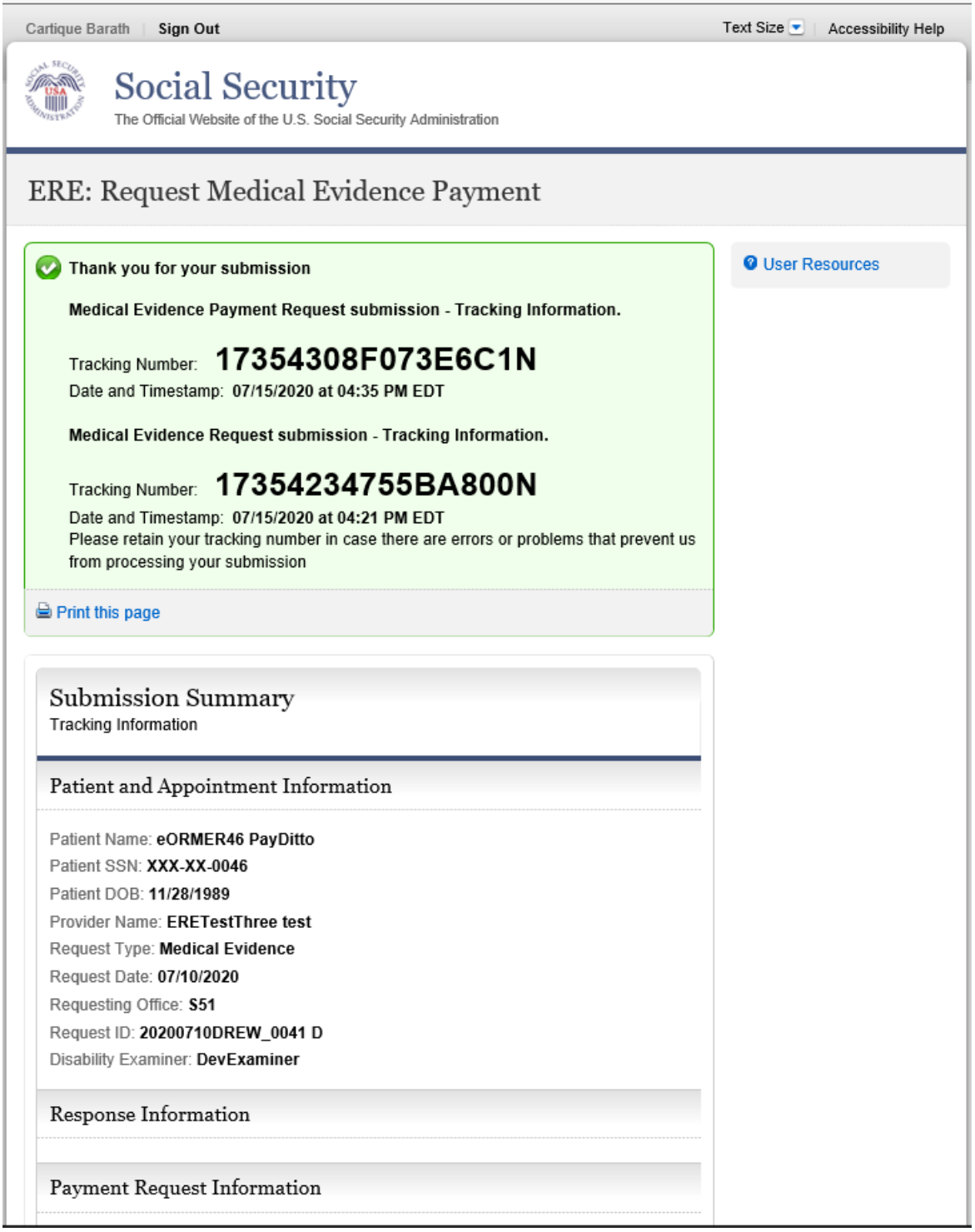
File Name	File Size
test-xls.xls	14 KB
Total File Size	14 KB

Invoice Type: **Both**

Your payment request was electronically signed.

ERE Home | Request Another Payment

No Invoices Tracking Page



DDS Invoice/Voucher Number: **1326**
Legacy Case Number: **677182**
Other DDS Number: **DDS9803**
Provider Name: **ERETestThree test**
Provider Title: **Mr**
Organization Name: **TestOrg**
Invoice Number:
Taxpayer ID: **113457**
Payee Taxpayer ID: **123456**
Payee Legal Entity Name: **ERETesteOR**
State Vendor Code: **MER**
Remit Address: **11 Woods, 15 testing palace, test area, test4, Westmead, MD-Maryland, 21044**
Phone Number: **(404) 496-9664 ext. 125**
Fax Number:
Provider Information changed: **Yes**
Payment Requested Amount: **$100.75**

File Name	File Size
No invoices were submitted during this submission	

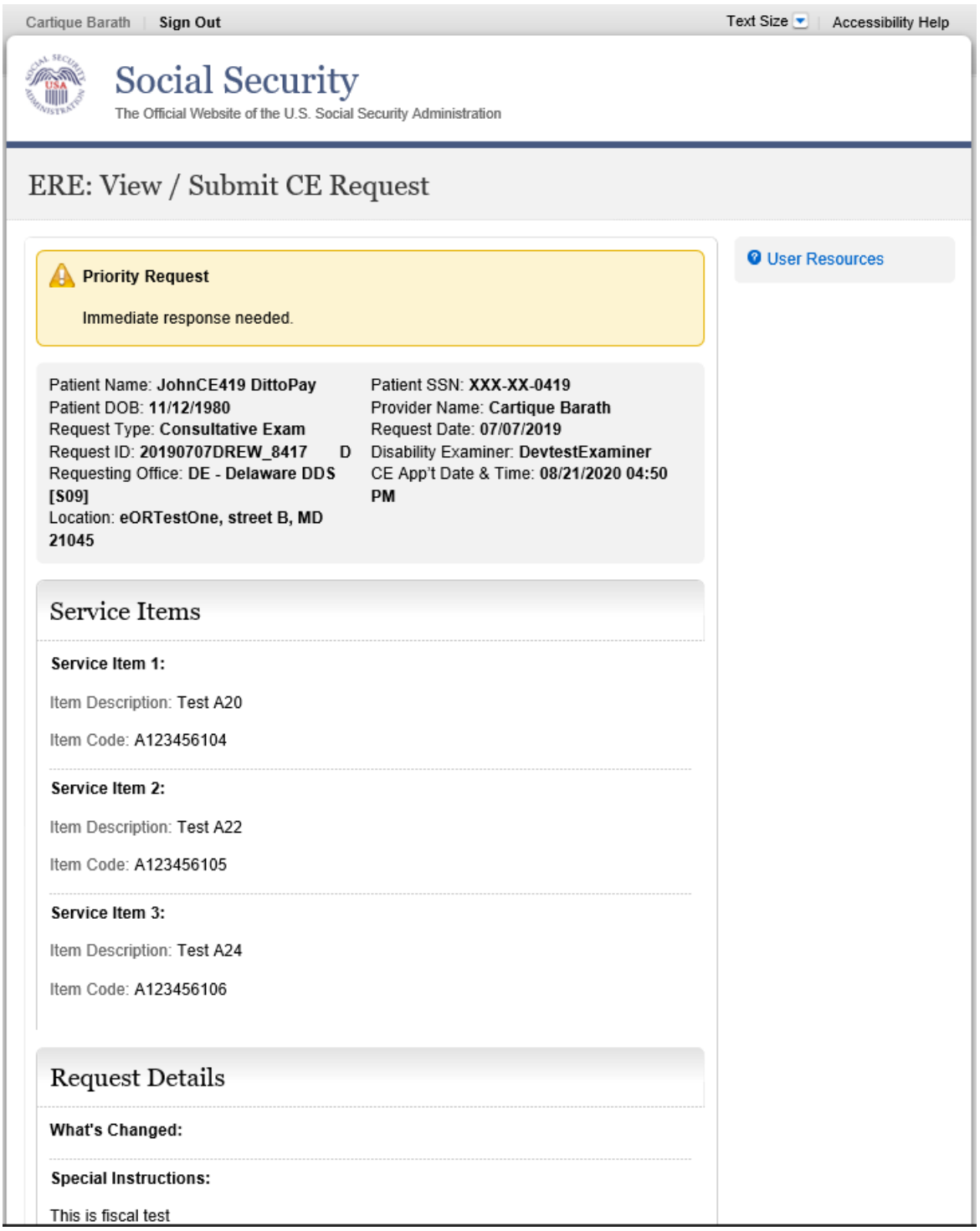
Your payment request was electronically signed.

ERE Home | Request Another Payment

Access Provider's Electronic Requests

Access Provider's Electronic Requests – Open Requests

View / Submit CE Request



Special Instructions:

This is fiscal test

Documentation:

File Name	Date Added
Request Letter	07/15/2020
Supporting Documentation	07/15/2020
Supporting Documentation	07/15/2020

Request Response

Select a response:

- (•) Prepare Report for Provider
- ( ) Send No Show Response

Attach and Upload Files

- A maximum of 25 files can be added and all files must total less than 200MB.
- File types accepted: .wpd, .doc, .docx, .jpg, .bmp, .txt, .xls, .xlsx, .pdf, .rtf, .tiff, .tif
- Please do not upload password-protected files because they cannot be processed.

Document Type:

Consultative Examination Report (CE) - 0002

Add Files: Browse...

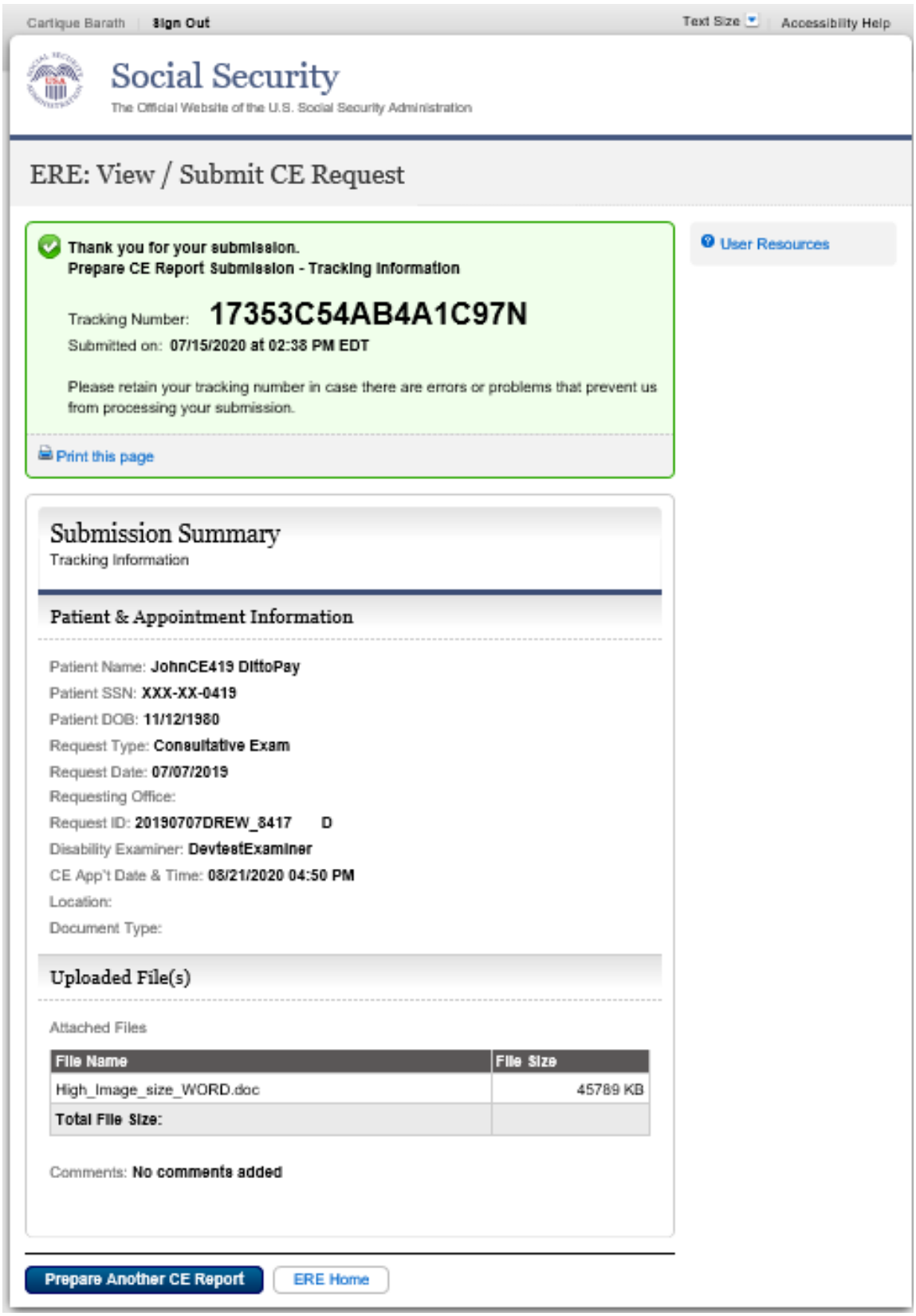
Additional Information

Comments (Optional):
(4,000 characters maximum)

Characters remaining: 4000

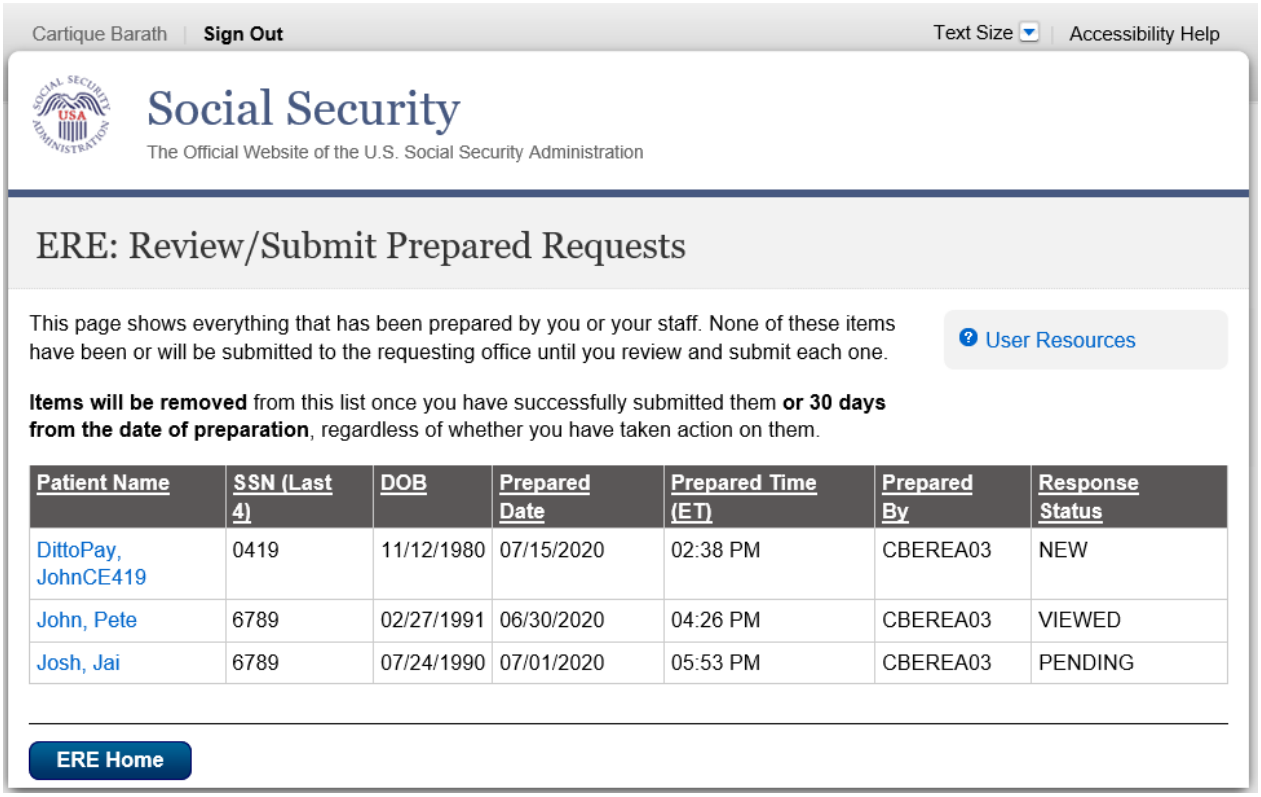
Send to Provider | Previous | Cancel

Tracking Page

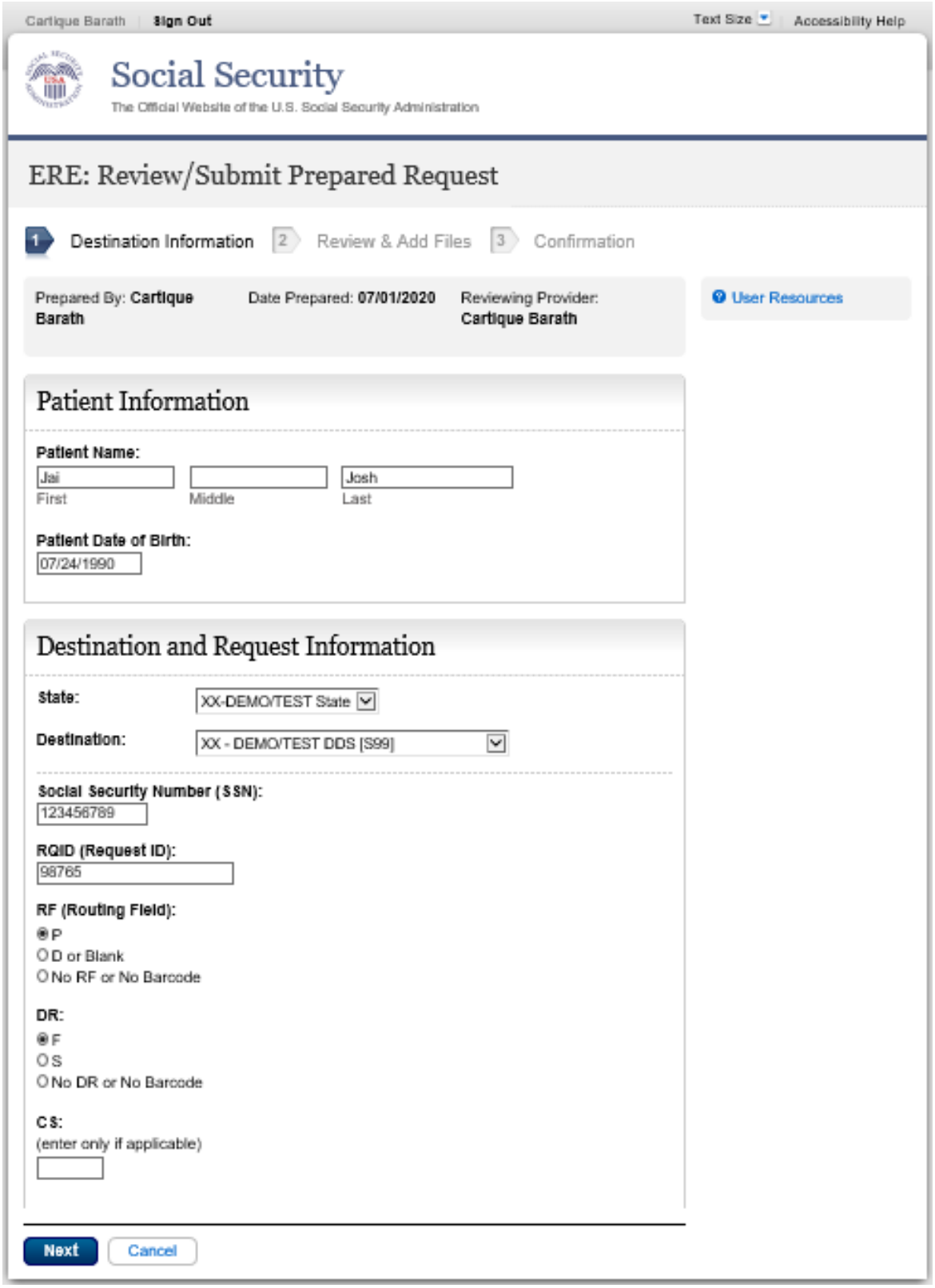


Review / Submit Prepared Requests

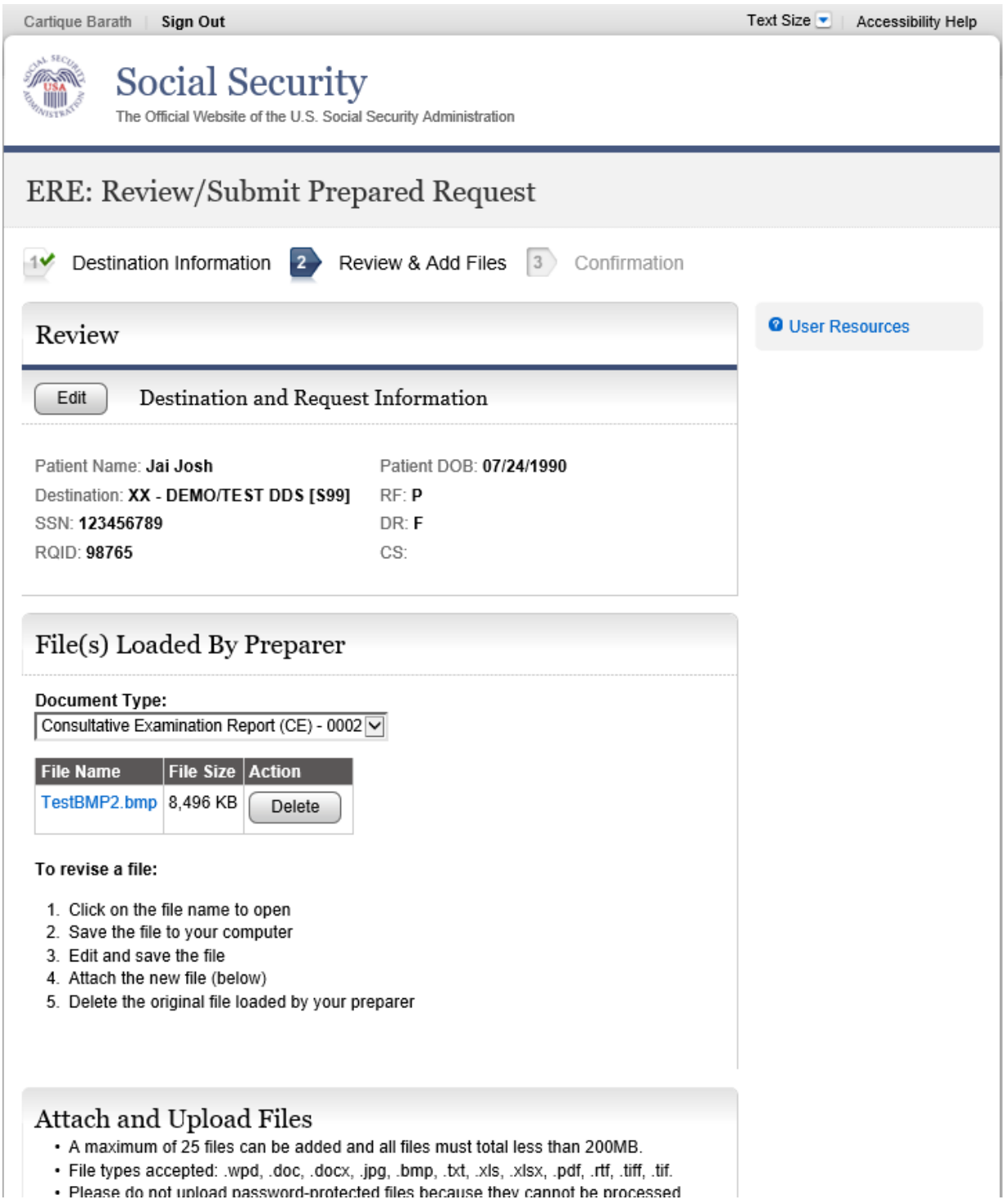
List of Requests



non-eOR - Patient Information & Destination and Request Information



non-eOR - Review & Add Files



- Please do not upload password-protected files because they cannot be processed.

Add Files: Browse...

Additional Information

Comments (optional):
(16,000 characters Maximum)

Characters remaining: 16000

Consultative Examination Authorization Agreement

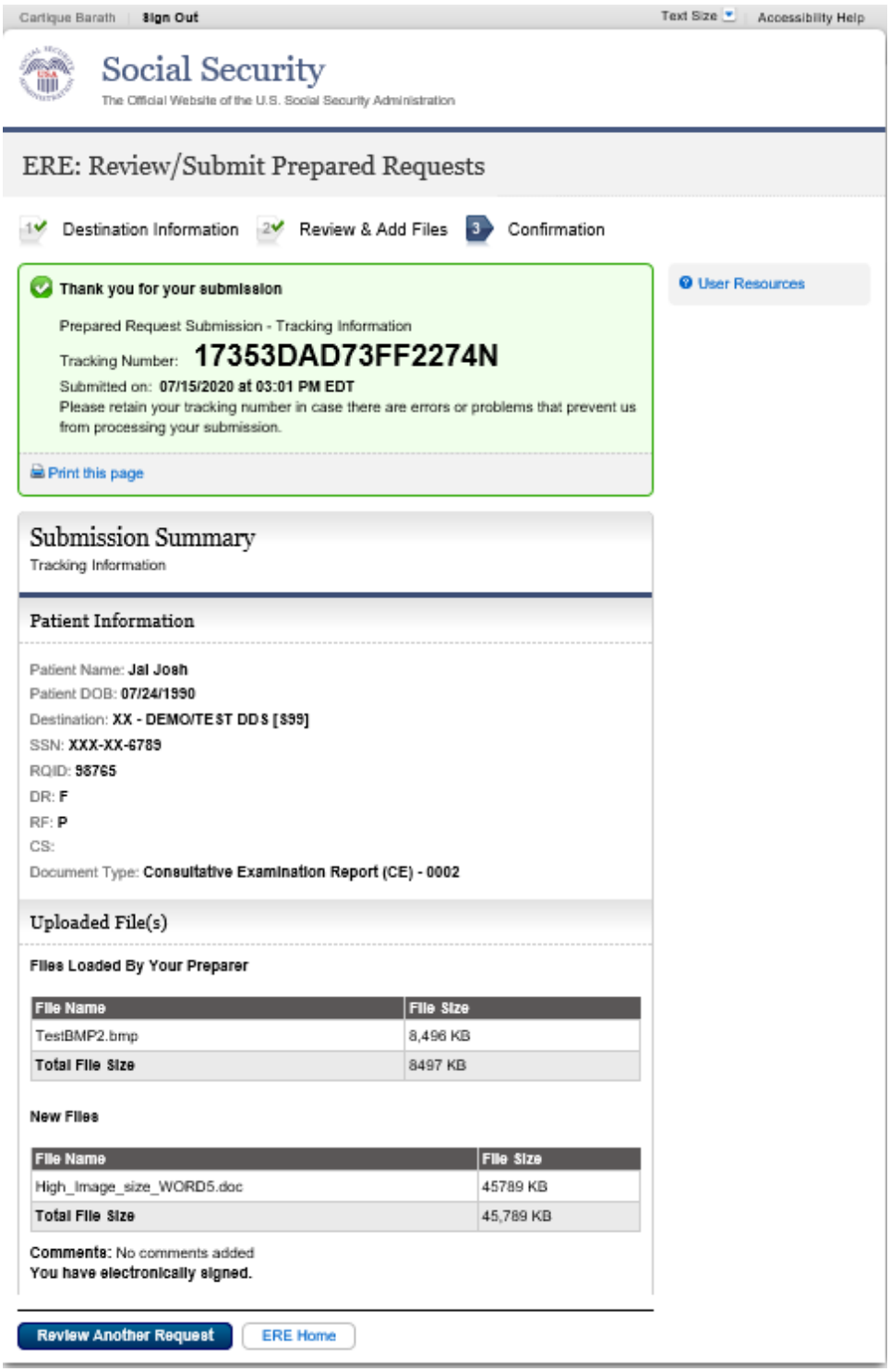
Please read this statement and indicate your agreement by checking the "I have read..." box. When you select "Submit", you will generate an electronic signature for your response.

I am certifying under penalty of perjury, that I have been authorized or contracted by the Disability Determination Services to examine the claimant. The report is accurate. By checking the "I have read and agree" checkbox below, I am certifying that I personally conducted, or personally participated in conducting, the consultative examination and have electronically signed the report contained within.

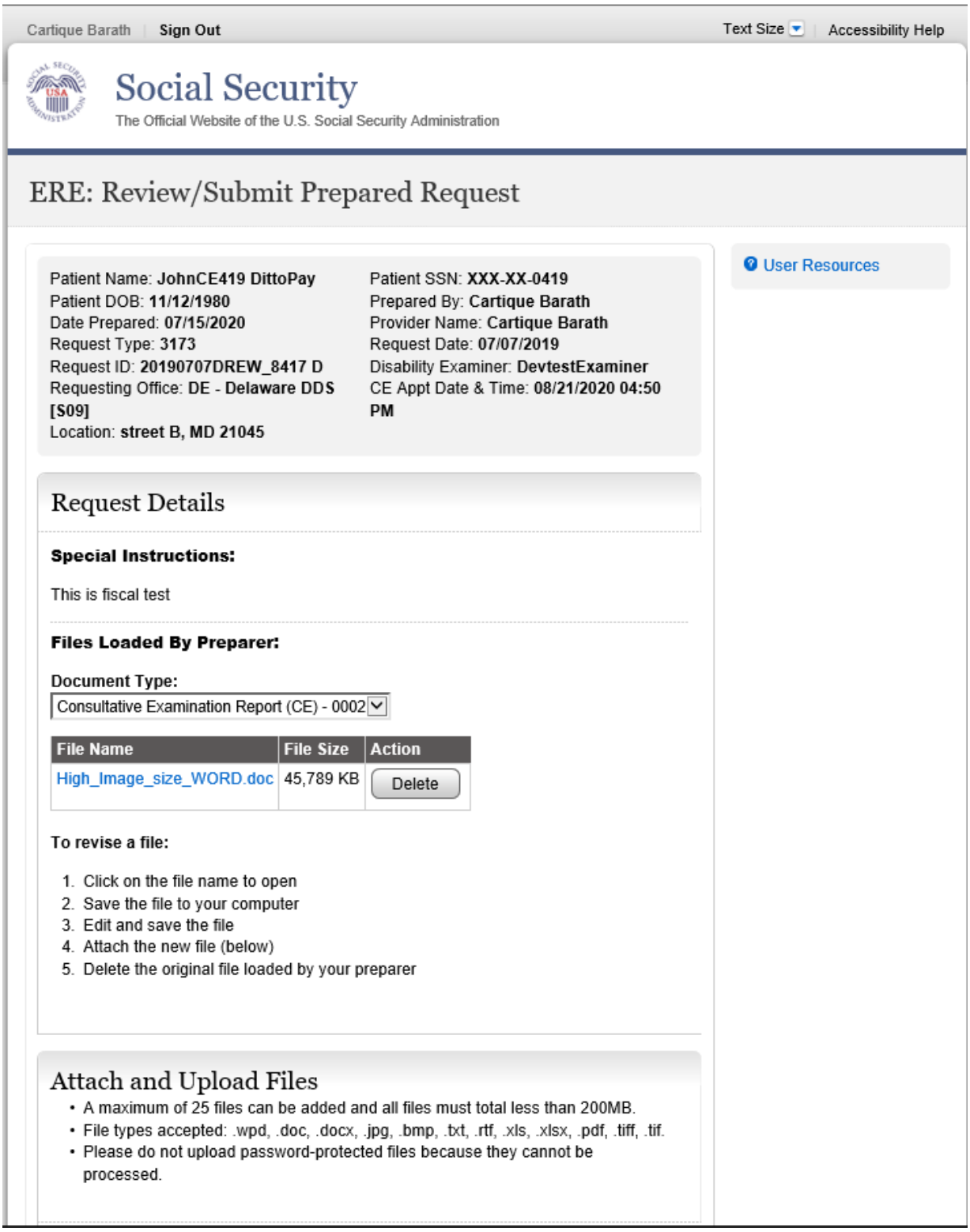
☐ **I have read and agree with the Agreement above.**

Submit Previous Cancel

non-eOR - Tracking Page



eOR - Review and Add Files



Add Files: Browse...

Additional Information

Comments (optional):
(4,000 characters maximum)

Characters remaining: 4000

Consultative Examination Authorization Agreement

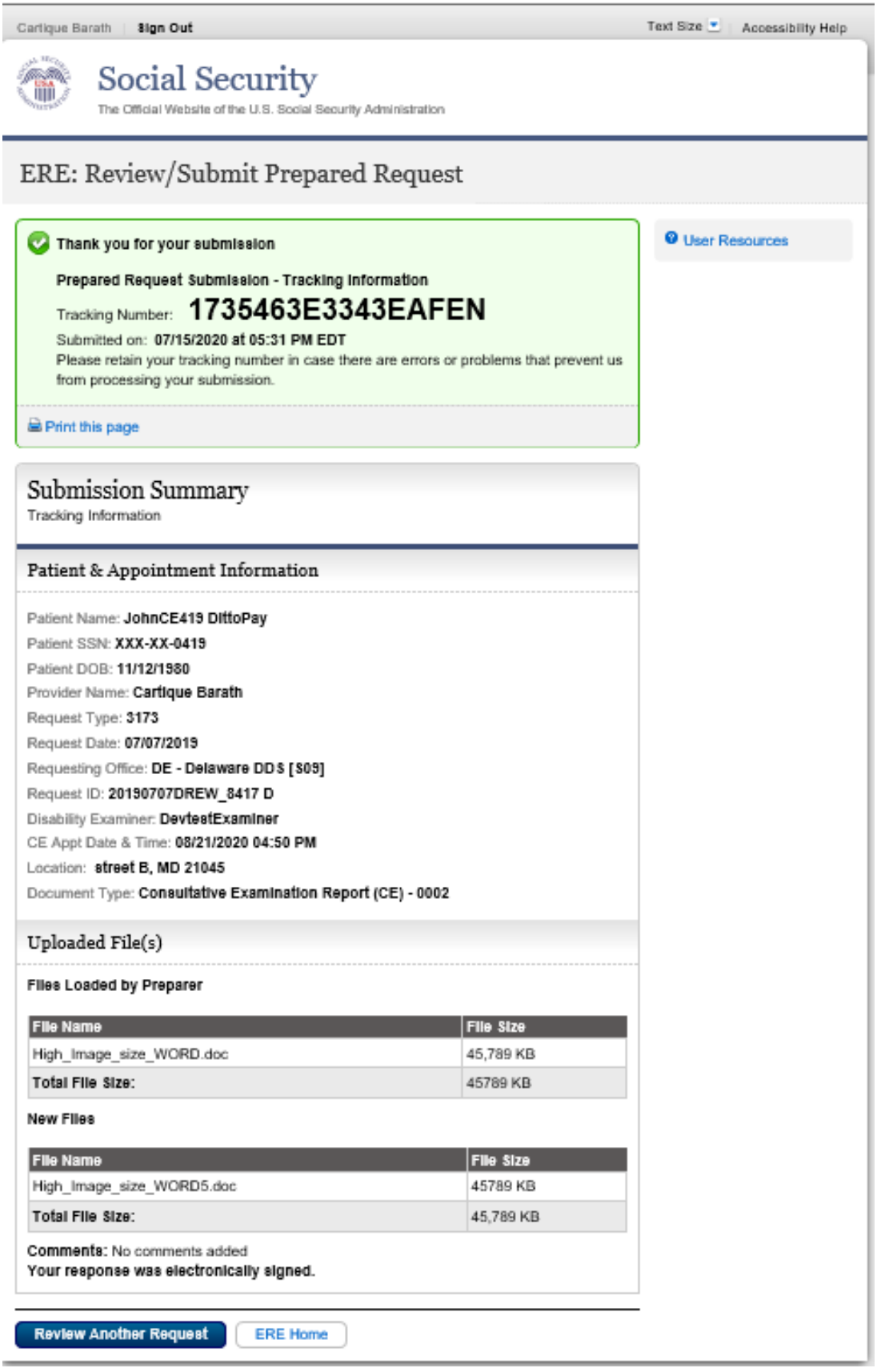
Please read this statement and indicate your agreement. When you select "Submit," you will generate an electronic signature for your response.

I am certifying under penalty of perjury, that I have been authorized or contracted by the Disability Determination Services to examine the claimant. The report is accurate. By checking the "I have read and agree" checkbox below, I am certifying that I personally conducted, or personally participated in conducting, the consultative examination and have electronically signed the report contained within.

☐ **I have read and agree with the Agreement above.**

Submit Cancel

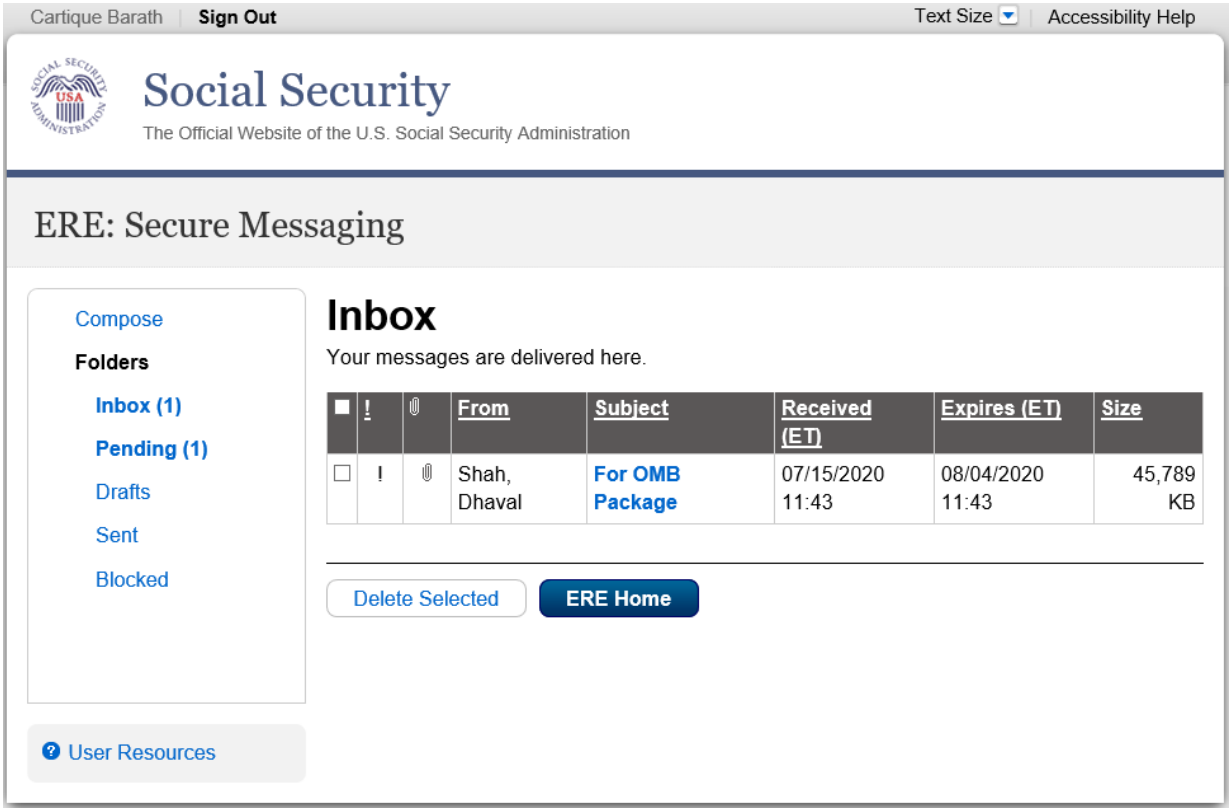
eOR – Tracking Page



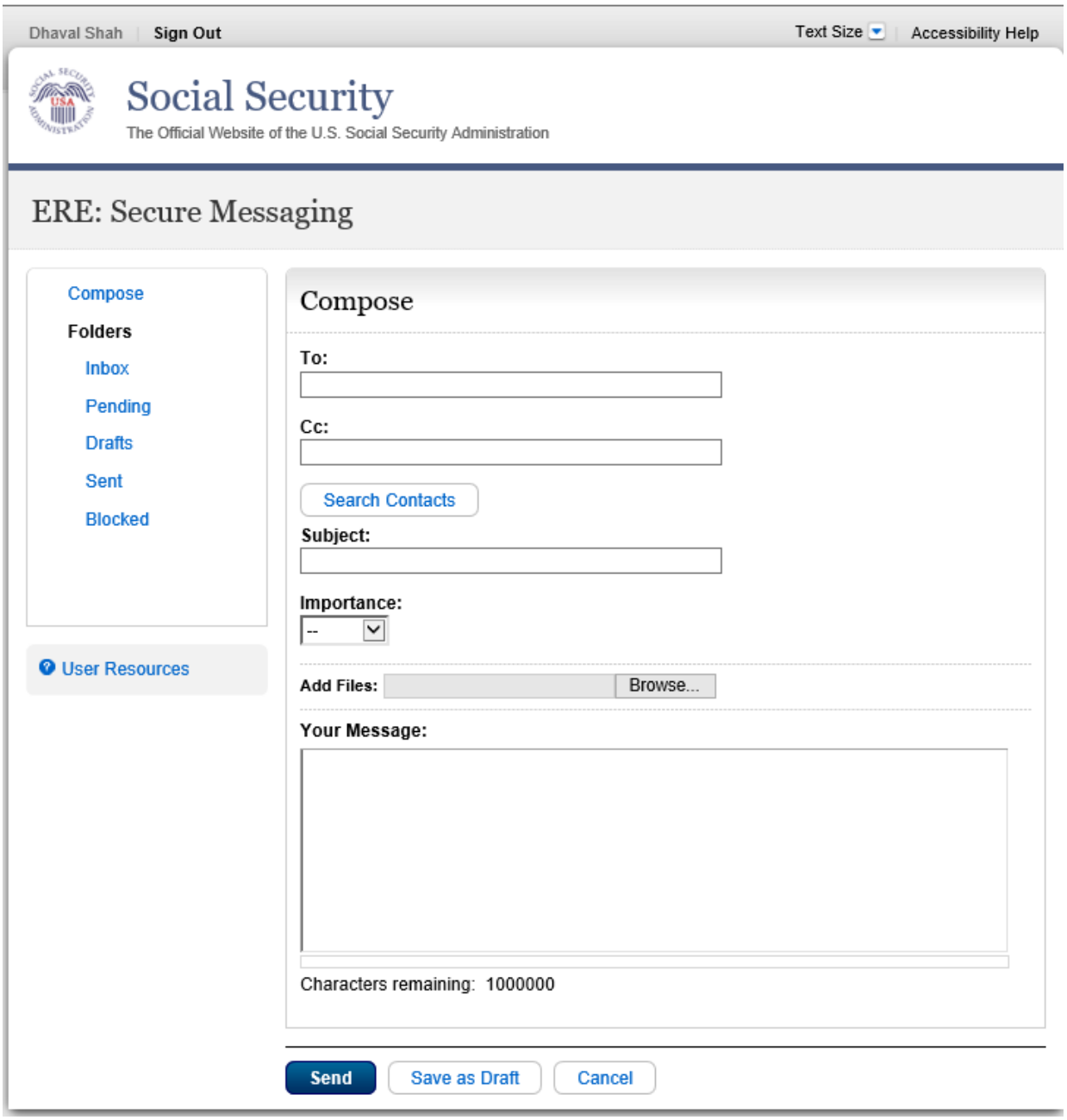
Messaging Services

Secure Messaging

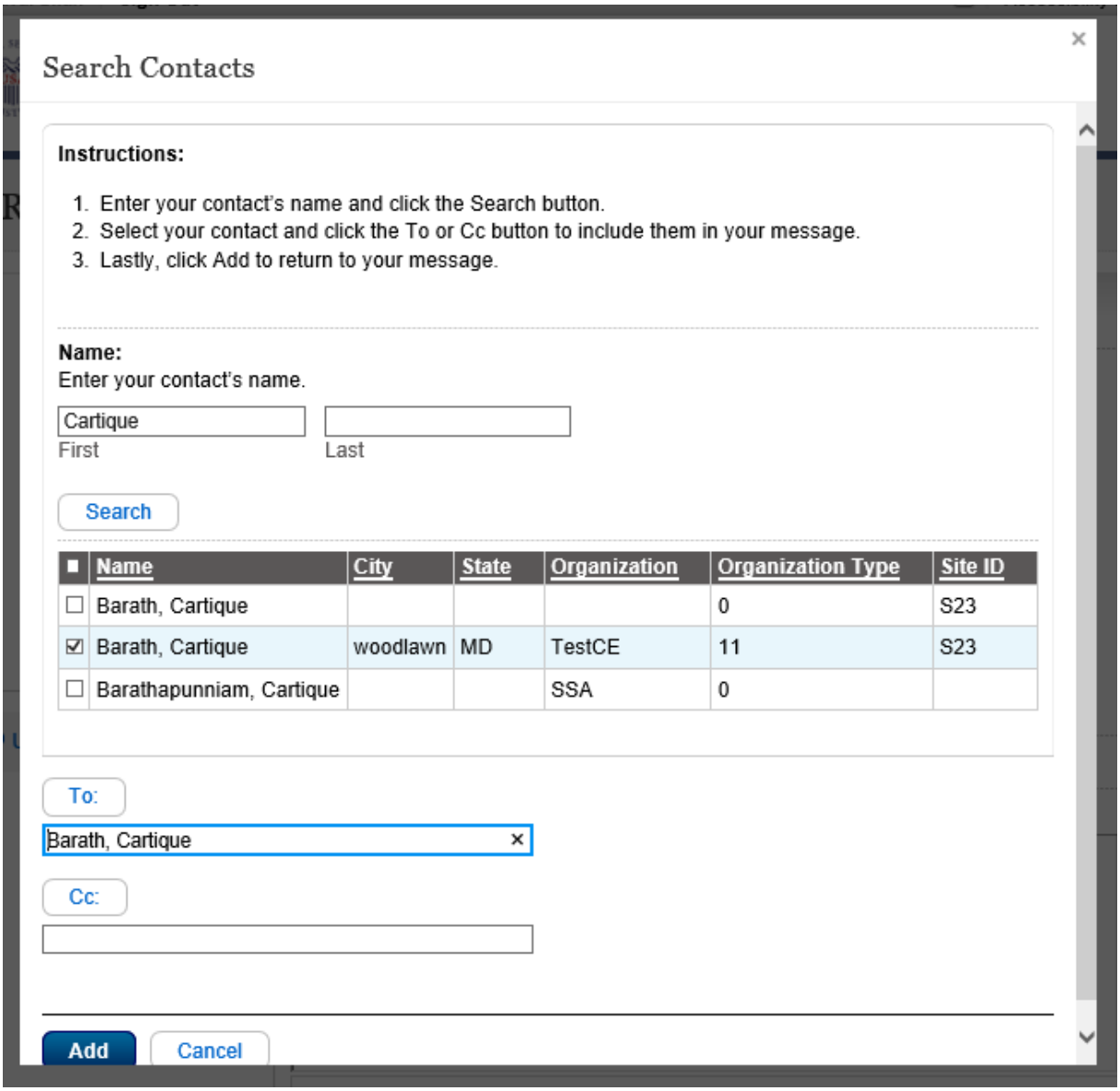
Inbox



Compose Message



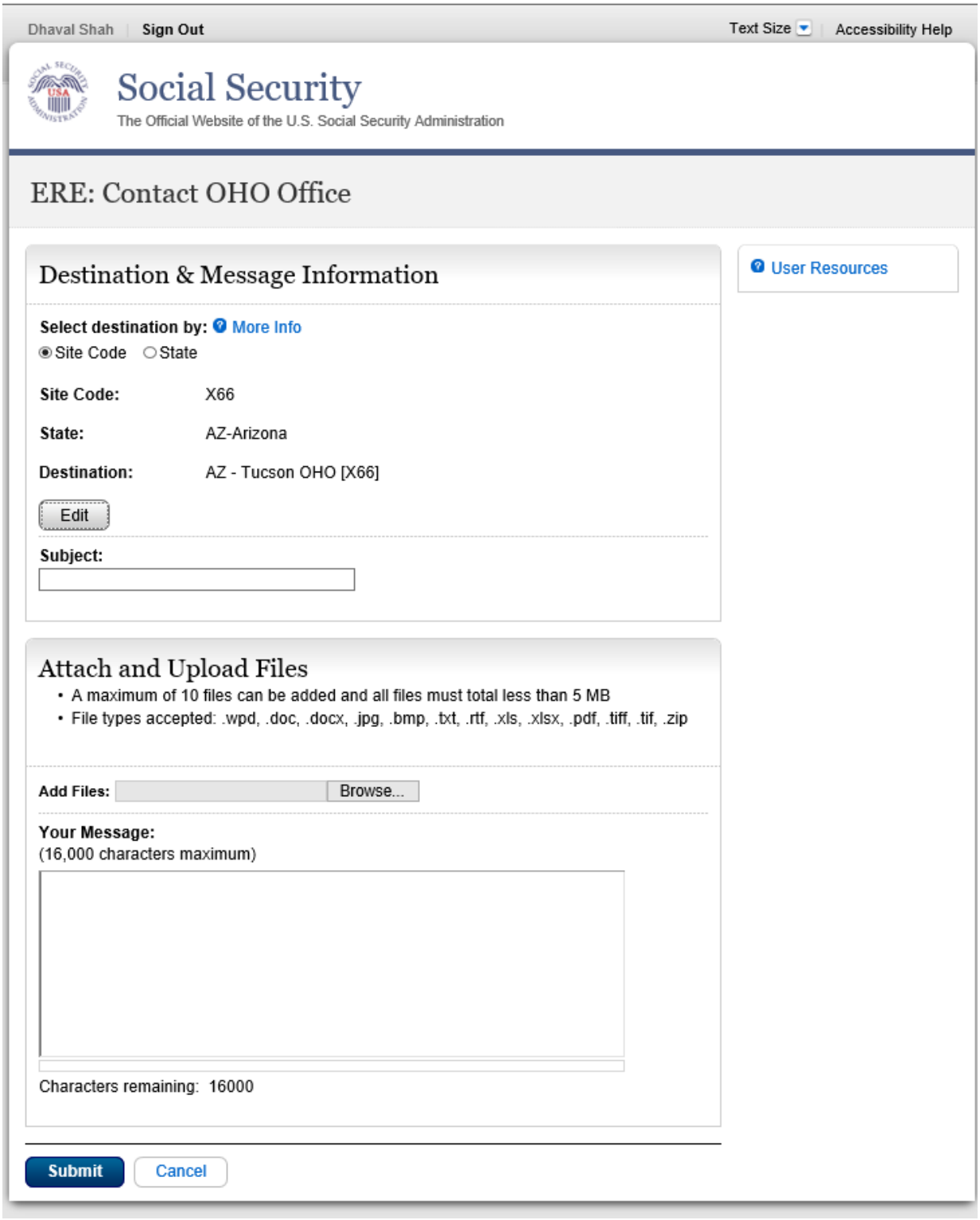
Search Contacts



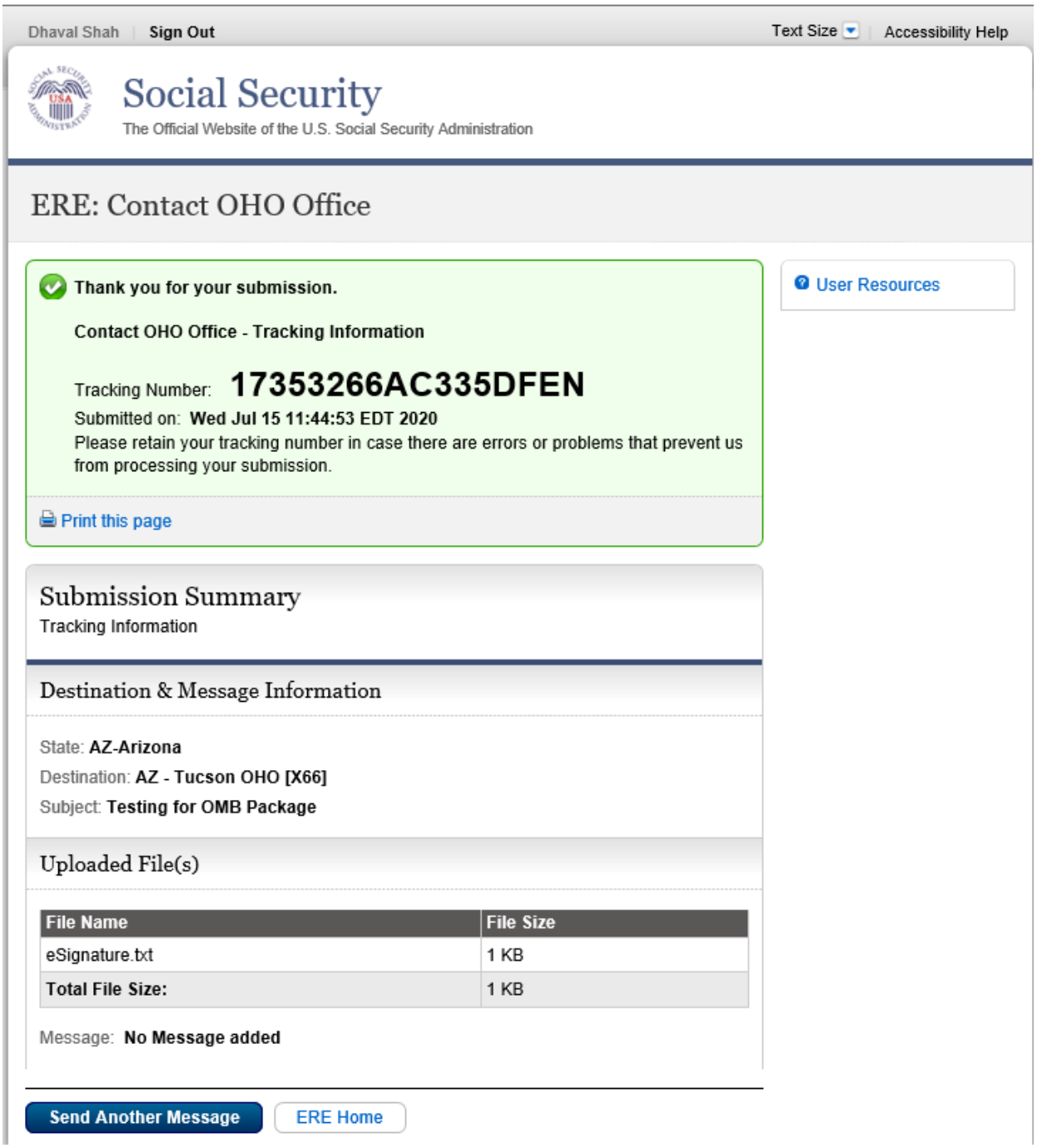
Compose Message – Confirmation

Contact OHO Office

Send Message and Files



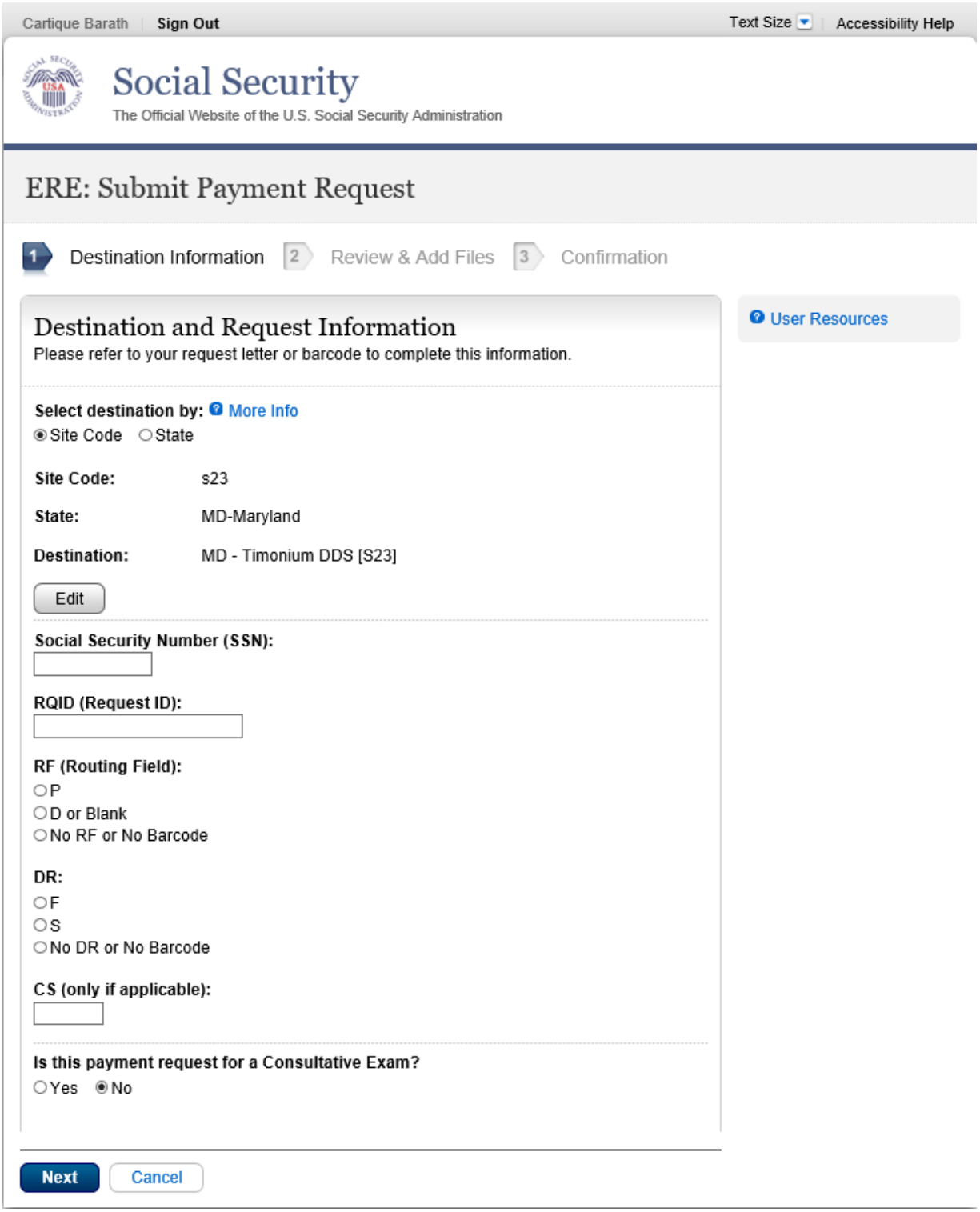
Confirmation



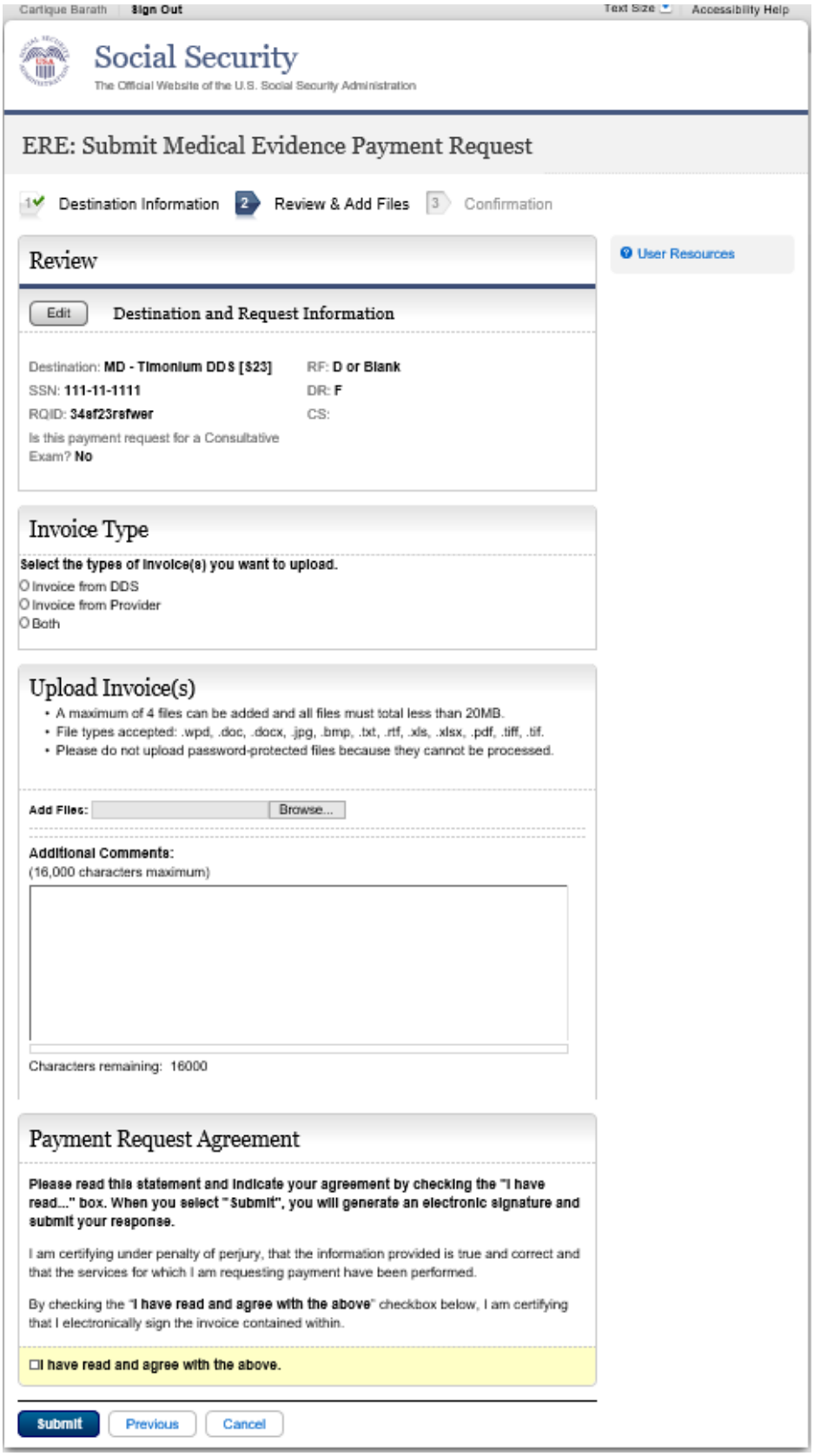
Payment Services

Submit Payment Request (non-eOR)

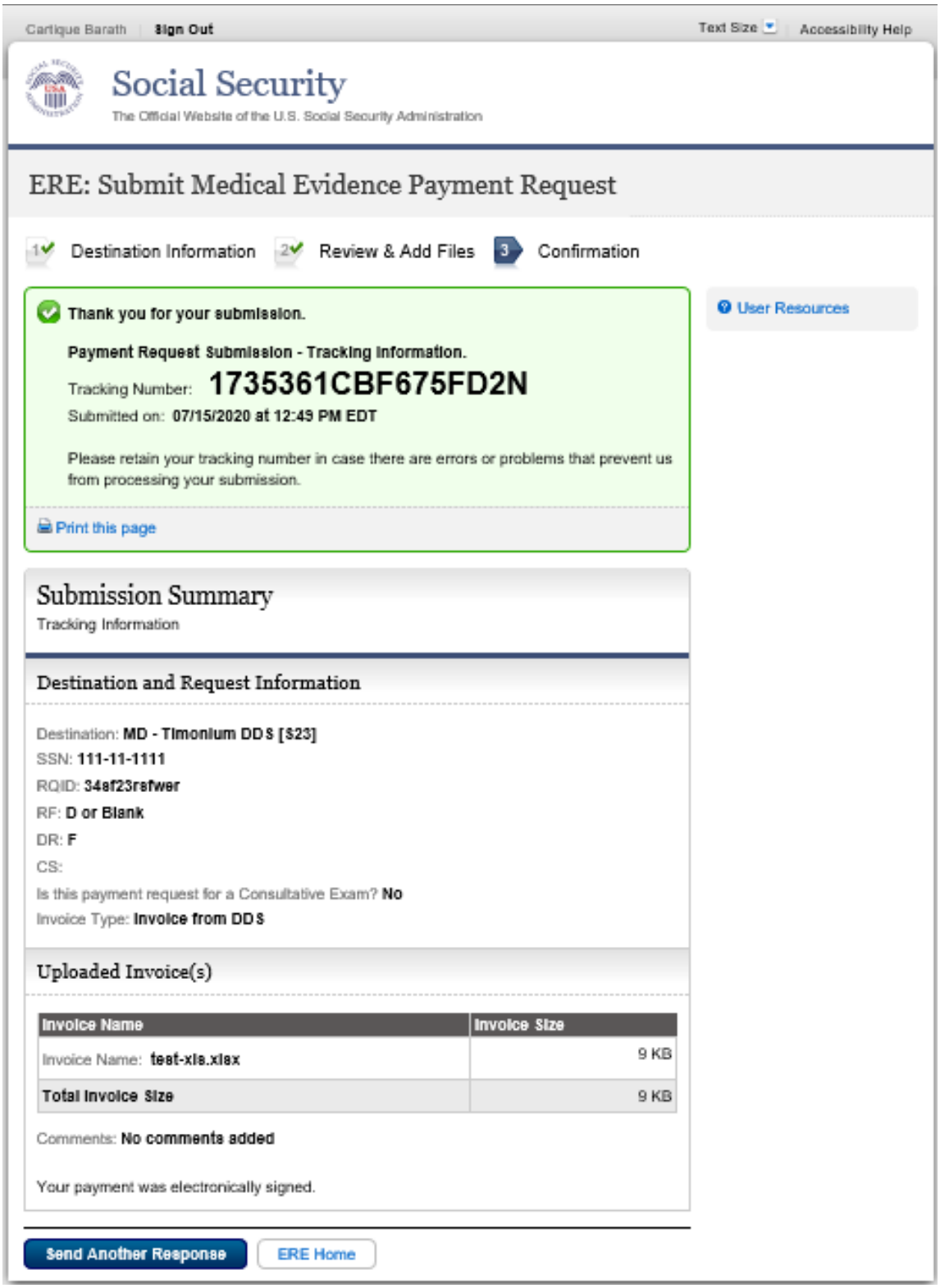
MER - Destination and Request Information



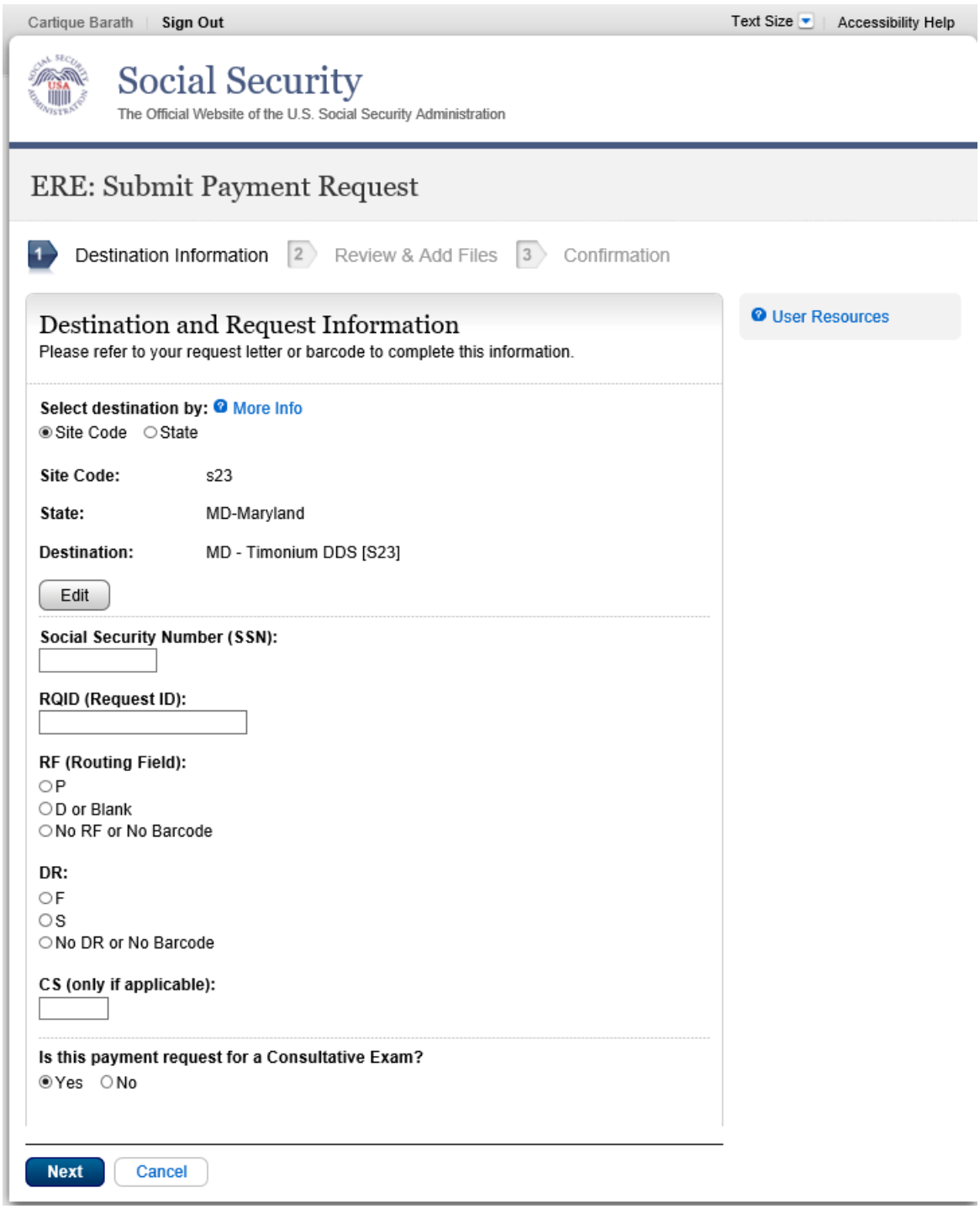
MER - Add Invoices



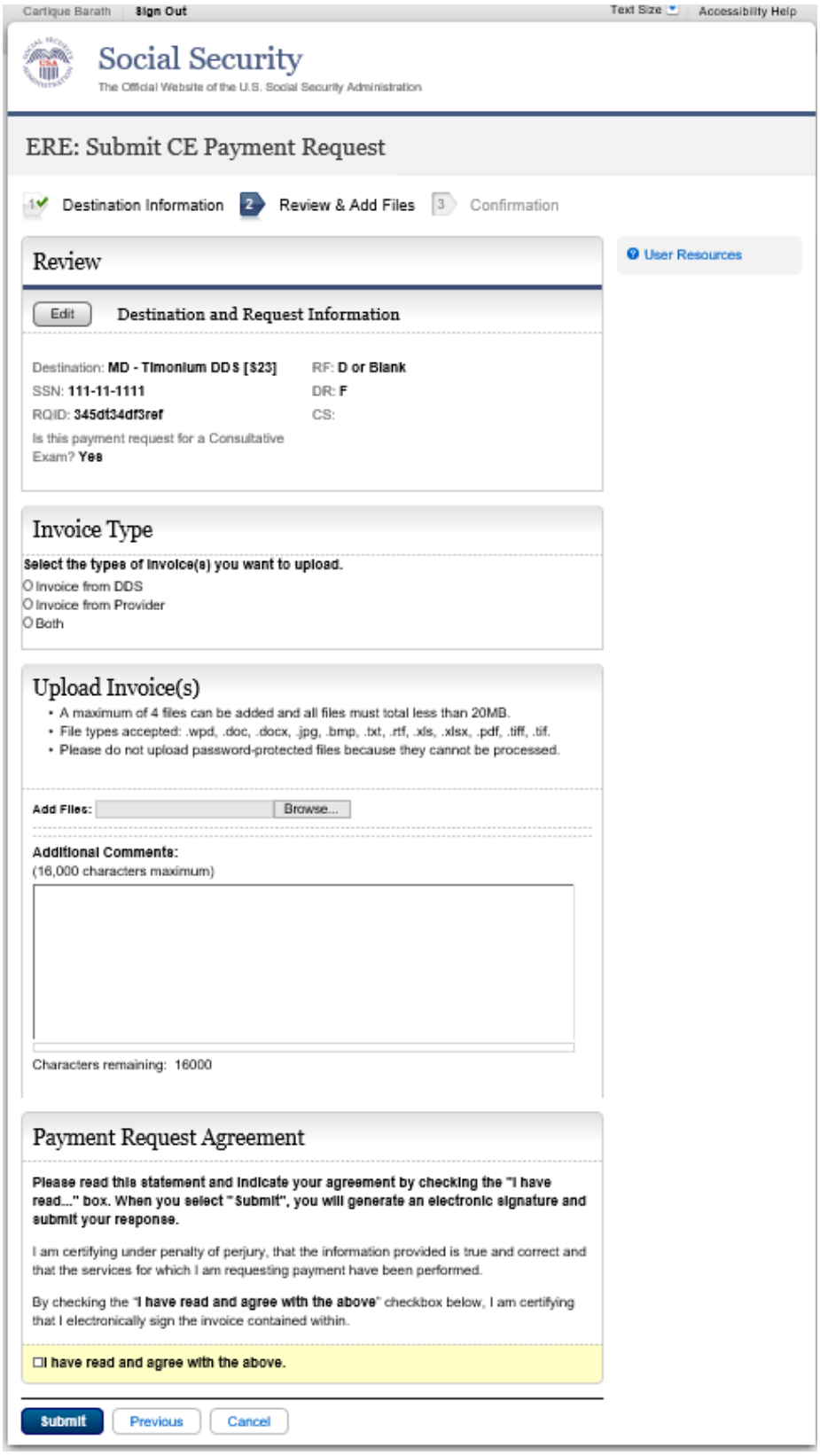
MER - Tracking Page



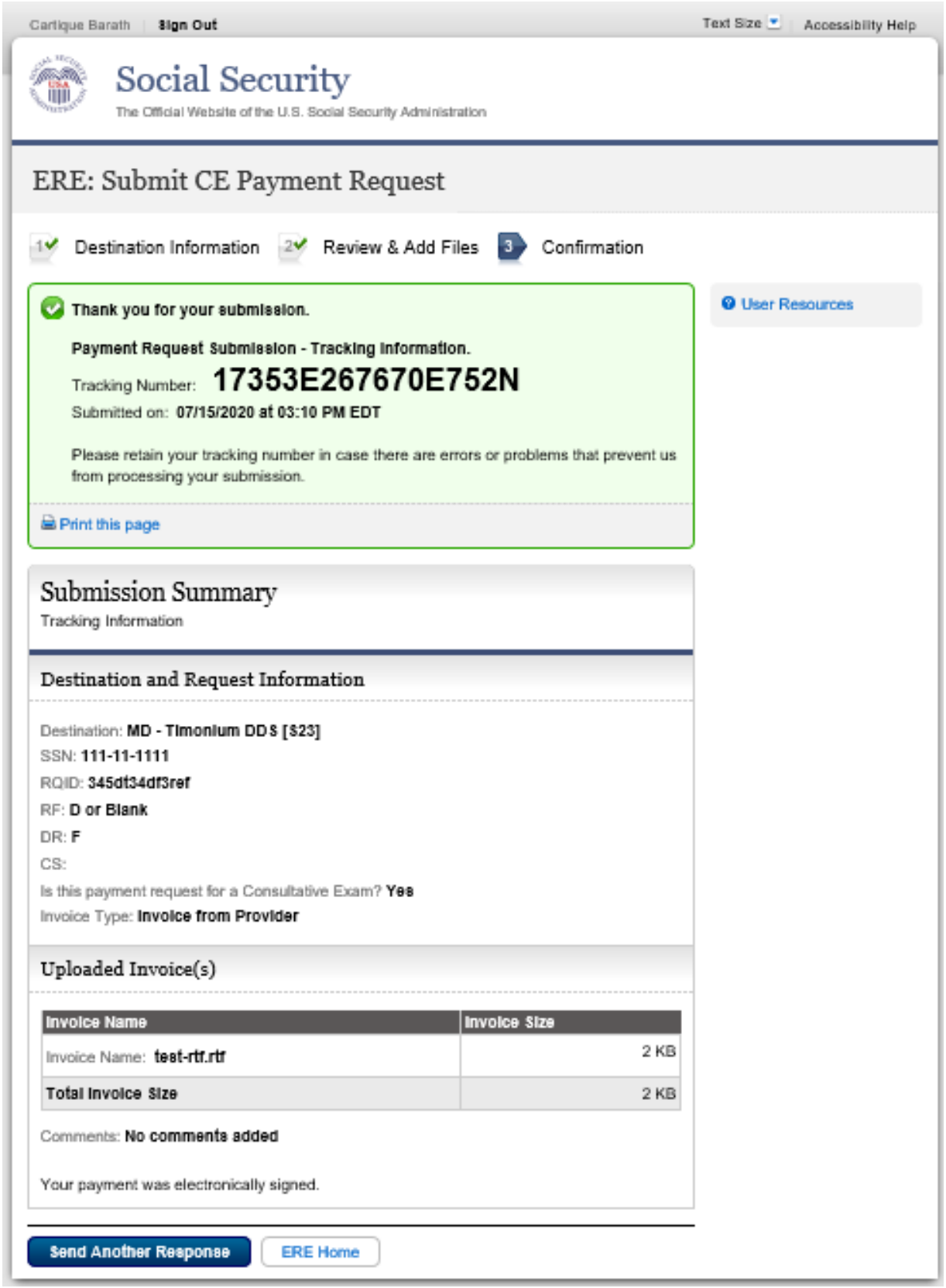
CE - Destination and Request Information



CE – Add Invoices

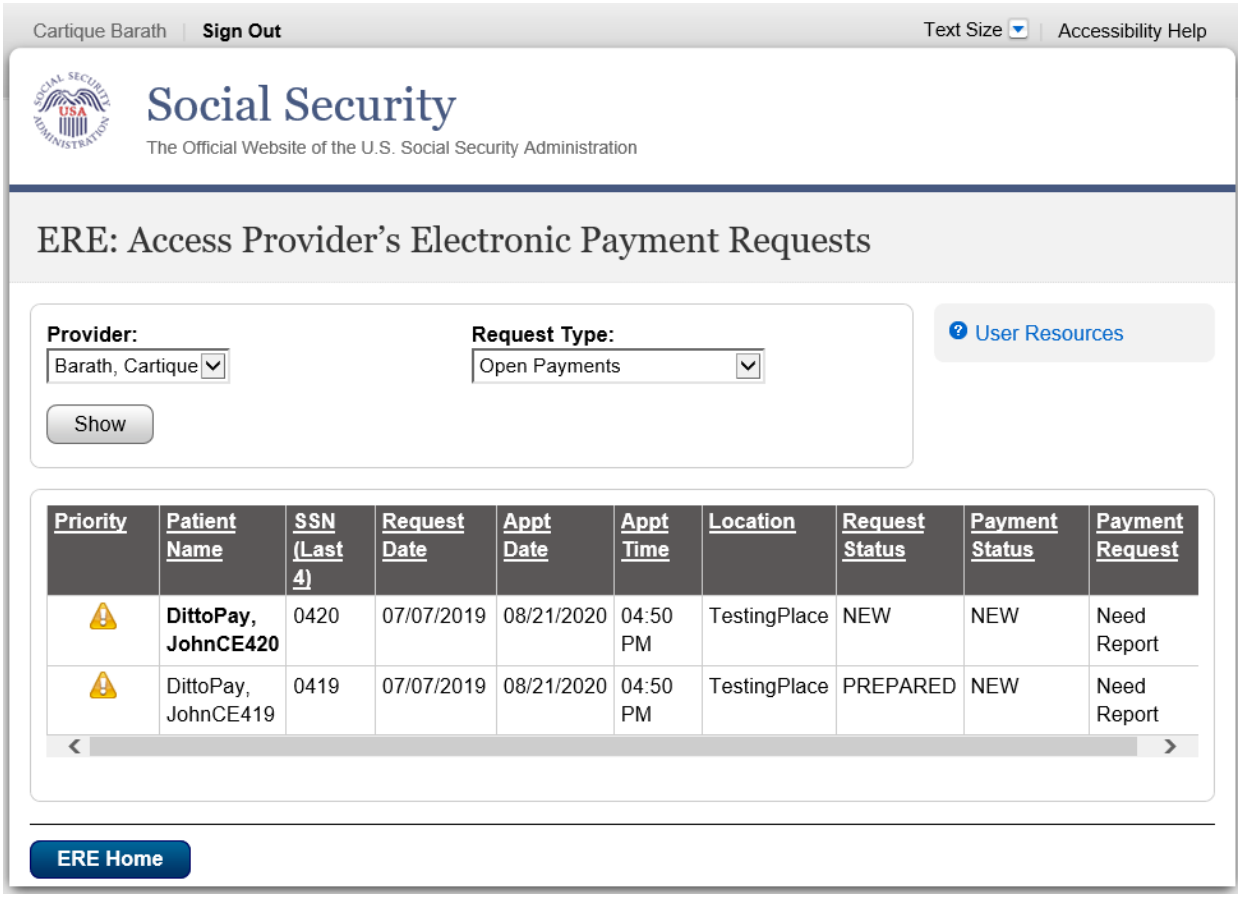


CE – Tracking Page



Access Provider's Electronic Requests

Open Payments (no reports submitted yet)



Open Payments (report submitted)