



SOCIAL SECURITY ADMINISTRATION

Refer To:
[ClaimantFirstName][ClaimantMiddleName]
[ClaimantLastName][ClaimantSuffix]
DOB: [ClaimantDOB]
BNC#: [BeneficiaryNoticeControl]

[LocalOfficeAddress]
Tel: [LocalOfficePhone] / Fax:
[LocalOfficeFax]
[Today's Date]



[HospitalPersonName]
[HospitalOrganizationName]
[HospitalAddress]

A claim for disability benefits, filed by the above-named individual under the Social Security Act, is before the Social Security Administration for hearing and decision.

Please provide the following information within the next ten days:
[Information to provide]

<if CEF>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- [DMAFaxNumber]. 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.<endif>

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><endif>
<elseifNoAuthorizedFee>We are not required to pay for medical evidence in this state. <endif>If you have any questions, please contact <ifPointOfContact>[PointOfContactFullName]<elseif GroupSup>[GroupSupervisorFullName]<elseif HOCALJ>[HOCALJFullName]<elseif HOD>[HODFullName]<endif> at the phone number listed above.

Thank you for your cooperation.

Sincerely,

Form HA-L67 (12-2025)

<if ClmtCopy>Claimant<elseif RepCopy>Representative<endif>
See Next Page

<if GroupSup>
[GroupSupervisorFullName]
Group Supervisor
<elseif HOCALJ>
[HOCALJFullName]
Hearing Office Chief Administrative
Law Judge
<elseif HOD>
[HODFullName]
Hearing Office Director
<endif>

Enclosures

<if MSS Physical>[Form HA-1151 Medical Statement of Ability to do Work-Related Activities \(Physical\)](#)

<endif>

<if MSS Mental>[Form HA-1152 Medical Statement of Ability to do Work-Related Activities \(Mental\)](#)

<endif>

cc: <if OBO>[OBOFirstName][OBOMiddleName][OBOLastName][OBOSuffix] on behalf of
[ClaimantFirstName][ClaimantLastName]
[OBOAddress]

<else>

[ClaimantFirstName][ClaimantMiddleName][ClaimantLastName][ClaimantSuffix]
[ClaimantAddress]

<endif>

<if Rep>

[RepFirstName][RepMiddleName][RepLastName][RepSuffix]

<if RepFirm>[RepFirm]<endif>

[RepFirmAddress]

<endif>

<if AuthorizedPayment>

[HospitalPersonName]

[HospitalOrganizationName]

[HospitalAddress]

Medical Source Information (to be completed by physician)

Signature: _____ Amount: _____

SSN or, if incorporated, EIN: _____ 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: _____

<endif>

Privacy Act Statement Collection and Use of Personal Information

Sections 205(b), 205(d), and 1631(c) 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 completing the hearing process.

We will use the information you provide to document your waiver of right to receive a written Notice of Hearing. We may also share the information for the following purposes, called routine uses:

- 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 a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records; and
- To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for SSA as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned Agency functions.

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 (SORNs) 60-0005, Administrative Law Judge Working File on Claimant Cases, as published in the Federal Register (FR) on April 29, 2009, at 74 FR 19617; 60-0089, Claims Folder Systems, as published in the FR on October 31, 2019, at 84 FR 58422; and 60-0320, Electronic Disability (eDIB) Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 2 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***

<if Fully Electronic=true>



INSERT THIS END FIRST



**Please include this barcode cover sheet as the first page
of each set of documents returned**



RQID: SITE:T21 DR:F
SSN:***** DOCTYPE:0001 RF: CS:4ef5

Fax Number: [DMAFaxNumber]

**Claimant: [ClaimantFirstName][ClaimantMiddleName]
[ClaimantLastName][ClaimantSuffix]**

<endif>