
SOCIAL SECURITY
USA
ADMINISTRATION

Effective Date:

March 16, 2012

Representatives must submit the following electronically:

- Request for appeal forms i561 and i501
- The Disability Report-Appeal form i3441

And continue to submit paper documentation, such as:

- SSA-827, SSA-3881, SSA-1696

If you answer yes to all these questions:

- Are you eligible for direct fee payment?

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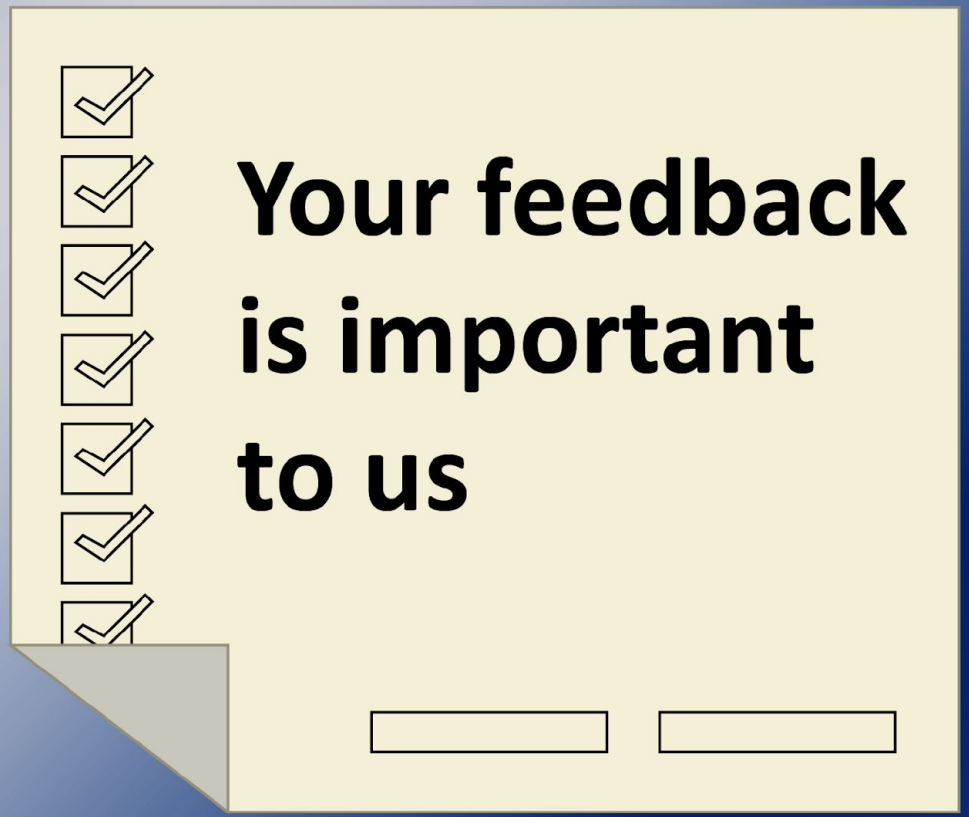
- Are you eligible for direct fee payment?
- Are you asking us to pay you directly in this particular case?

If you answer yes to all these questions:

- Are you eligible for direct fee payment?
- Are you asking us to pay you directly in this particular case?
- Did we deny your client's original claim for medical reasons?

Then you must file the appeal electronically.

Please take a few minutes to fill out our brief survey



1) Your client has applied for disability benefits

1) Your client has applied for disability benefits
2) Your client has received a notice of decision

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2) Your client has received a notice of decision
3) Your client disagrees with the disability decision and wants to file an appeal

1) Your client has applied for disability benefits
2) Your client has received a notice of decision
3) Your client disagrees with the disability decision and wants to file an appeal
4) You client lives in the United States or one of its territories

Contact Social Security at:

1-800-772-1213

(TTY)

1-800-325-0778

Visit the website:

www.socialsecurity.gov/disability/appeal

Hours of Operation

- Weekdays: 5am - 1am ET

Hours of Operation

- Weekdays: 5am - 1am ET
- Saturdays: 5am – 11pm ET

Hours of Operation

- Weekdays: 5am - 1am ET
- Saturdays: 5am – 11pm ET
- Sundays: 8am – 10pm ET

Hours of Operation

- Weekdays: 5am - 1am ET
- Saturdays: 5am – 11pm ET
- Sundays: 8am – 10pm ET
- Select Holidays: 5am – 11pm ET

It can take up to
1 hour to complete
the forms online.

First Part:

Disability Internet Appeal Request

20 mins

Second Part:
Disability Report

40 mins

Social Security Online
www.socialsecurity.gov

Disability Appeal

Welcome. Thank you for filing your disability appeal online.

Before you begin...

You need to have your Notice of Decision.

We recommend you review the following links:

- Video: Preparing to File Your Disability Appeal Online
- Checklist: Information You Will Need
- Tips for Using this Website
- Instructions for Blind or Visually Impaired Users

You may also want to review:

- Social Security's Definition of Disability
- How the Disability Appeal Process Works
  Information About Social Security's Disability
- Programs
- Your Right to Representation
- Other Ways to Complete a Disability Appeal

To start your disability appeal...

Please read Tips for Using this Website.

Start Your Appeal

To continue working on your disability appeal...

If you want to finish a disability appeal you already started:

Go Back to the Appeal You Already Started

Contact Us | Tips for Using this Website

- Your client's name, Social Security Number, address, and phone number

- Your client's name, Social Security Number, address, and phone number
- Your client's Notice of Decision

- Your client's name, Social Security Number, address, and phone number
- Your client's Notice of Decision
- Your name, address, and phone number

- Your client's name, Social Security Number, address, and phone number
- Your client's Notice of Decision
- Your name, address, and phone number
- The name, address, and phone number of a friend or relative who knows about your client's medical condition

- A description of any changes in previously reported medical conditions

- A description of any changes in previously reported medical conditions
- New medical conditions

- A description of any changes in previously reported medical conditions
- New medical conditions
- The name, address, phone number, type of treatment, and visit dates for all doctors, hospitals, and clinics

- The names of over-the-counter and prescription medicines your client currently takes, who prescribed them, and any side effects

- The names of over-the-counter and prescription medicines your client currently takes, who prescribed them, and any side effects
- The name, location, and date of all medical tests you have had and who
sent your client for them


Social Security Online
www.socialsecurity.gov
Disability Appeal
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- Your answers are saved automatically when you select “Next”

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- To complete the appeal later, you can select "Sign Off finish later" after you receive a reentry number.

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- To complete the appeal later, you can select "Sign Off finish later" after you receive a reentry number.
- You can print the summary page for your records.

- We recommend you make sure your printer is working properly before you begin the application.

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- If you want a copy of all of your answers, you will need to print or save each page.

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- If you want a copy of all of your answers, you will need to print or save each page.
- When printing, use the print feature located in your web browser.

You will receive a time limit warning if you have been working on one page for longer than 25 minutes.

If you would like to continue, select the option to continue working on that page when you see this message.

After three 25 minute warnings, you must move onto the next screen to prevent your information from being lost

- Items marked with an asterisk (*) are required.

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- To navigate within the appeal, use the “Next” and “Previous” buttons.

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- To navigate within the appeal, use the “Next” and “Previous” buttons.
- Do not use the “Back” button or “X” located in your browser.

- You can use the “Sign Off (finish later)” button once you have obtained your reentry number.

- You can use the “Sign Off (finish later)” button once you have obtained your reentry number.
- The summary pages have edit buttons if you would like to change information you entered.

Social Security Online
www.socialsecurity.gov

Disability Appeal

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Start Your Appeal

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Contact Us | Tips for Using this Website

Social Security Online

Disability Appeal

www.socialsecurity.gov

Can you use this online disability appeal?

Please note: if you are helping another person fill out this appeal, answer all of the questions as they apply to the person you are helping.

To complete an appeal online, you must have a notice of decision.

* **Do you live in the United States or one of its territories / commonwealths?**	○ **Yes** ○ **No**
* **Did you receive a notice of decision?**	○ **Yes** ○ **No**

Previous Next

Social Security Online

Disability Appeal

www.socialsecurity.gov

Claimant information

Please note: "Claimant" refers to the adult or child whose disability decision is being appealed.

*** Claimant Name:**

(Enter the First, Middle, and Last Name of the person applying for benefits.)

Suffix (if any)

*** Claimant Social Security Number:**

Please enter the Social Security Number without dashes or hyphens.

*** Claimant date of birth:**

*** What is the date on the "Notice of Decision" you received?**

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0823**

Request for reconsideration

OMB No. 0960-0622
Paperwork Reduction Act

Your privacy is important. For details about our use of your information, we encourage you to read our Privacy Act Statement.

Name of Claimant: John G Public

(First, Middle, Last)

*** Claimant Mailing Address:**

Please provide a complete address, including apartment number if applicable. Please do NOT use punctuation; for example, no periods or commas. Example: 528 Dawn St Apt 101. If the address on your notice is correct, please enter it exactly as it appears on the denial notice.

*** (Street Line 1)**

(Street Line 2)

(Street Line 3)

(Street Line 4)

*** (City, State, ZIP Code)** 21087

Claimant Telephone Number:

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0822**

Request for hearing by administrative law judge

OMB No. 0960-0269
Paperwork Reduction Act

Your privacy is important. For details about our use of your information, we encourage you to read our Privacy Act Statement.

Claimant Name: John G Public

(First, Middle, Last)

*** Claimant Address:**

Please provide a complete address, including apartment number if applicable. Please do NOT use punctuation; for example, no periods or commas. Example: 528 Dawn St Apt 101. If the address on your notice is correct, please enter it exactly as it appears on the denial notice.

*** (Street Line 1)**

(Street Line 2)

(Street Line 3)

(Street Line 4)

*** (City, State, ZIP Code)** 21087

Claimant Telephone Number:

Wage Earner Name (If different from Claimant): Suffix (if any)

(First, Middle, Last)

Who is the Wage Earner?

I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE.

Enter a brief explanation of the reason for your appeal. 205 character maximum. This is about 4 lines of typing.

Count Characters You have entered 0 characters

*** I disagree with the determination made on my claim because:**

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

*** I have additional evidence to submit:** Yes No

If yes, you will be asked to give us the name and address of the source of additional evidence in Part 2 of the Internet Appeal process. For more information about how to submit additional evidence, use the link Submitting Additional Evidence.

Do you wish to appear at a hearing?

*** Select one answer:**

- I wish to appear at a hearing.
- I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver of Your Right to Personal Appearance Before an ALJ, HA-4608.)

Enter a brief explanation of the reason for your appeal. 205 character maximum. This is about 4 lines of typing.

Count Characters You have entered 0 characters

*** I disagree with the determination made on my claim because:**

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

*** I have additional evidence to submit:** ○ Yes ○ No

If yes, you will be asked to give us the name and address of the source of additional evidence in Part 2 of the Internet Appeal process. For more information about how to submit additional evidence, use the link Submitting Additional Evidence.

Do you wish to appear at a hearing?

*** Select one answer:**

- ○ **I wish to appear at a hearing.**
- ○ **I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver of Your Right to Personal Appearance Before an ALJ , HA-4608.)**

You have a right to be represented at the hearing. Use this link if you want to know more about representatives.

*** Do you currently have a representative?** ○ Yes ○ No

*** Select one answer:**

- ○ **I am completing this form as the Claimant.**
- ○ **I am completing this form as the Claimant's Representative.**

Next

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0823**

Representative's information

You said earlier that the claimant has a representative. If this is not correct, you can

Change Your Answer

If the claimant has not done so previously, he or she may need to complete and submit a form SSA-1696 (Appointment of Representative). See About Your Right to Representation for more information.

*** Representative's Name:**

(First, Middle, Last)

Suffix (if any)

*** Is the Representative an attorney?** ○ Yes ○ No

*** Mailing Address:**

Please provide a complete address, including apartment number if applicable. Please do NOT use punctuation; for example, no periods or commas. Example: 528 Dawn St Apt 101

*** (Street Line 1)**

(Street Line 2)

(Street Line 3)

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0012**

Review and submit your request for hearing

Please review and submit your request for hearing below. If you need to make changes, select "Previous" to go back. To submit your request select "Submit" and continue to the next portion of your appeal.

The answers you provided are shown in bold text. This will be your last chance to change your answers.

Claimant's name is **John G Public** . The Claimant's mailing address is **555 Main Street, Anywhere, MD 21087** . The Claimant's phone number is **(410) 555-1212** .

If the Claimant has additional evidence such as a doctor's report, it should be sent to Social Security within 10 days.

I, Mike P Public, declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

☐ * **I, Mike P Public, have read and agree with the above.**

Previous Submit

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0013**

Print your reentry number and receipt

To print or save this page, please use your browser's Print button or File menu commands.

You have completed the initial portion of your disability appeal. You have provided enough information to obtain a receipt and reentry number. Your reentry number allows you to continue the appeal later if you cannot proceed at this time.

During the next, and final, part of the disability appeal process, we will ask you to provide information on your medical condition. This information is necessary to make a medical decision on your appeal. We recommend you complete your appeal now.
Select "Next" to continue.

Your reentry number is: 74549174

To continue with this appeal later, go to www.socialsecurity.gov/disability/appeal and select "Go Back to the Appeal You Already Started."

The Claimant is represented by Mike P Public, who is an attorney. If not done so previously, the Claimant will complete and submit form SSA-1696 (Appointment of Representative). The Representative's mailing address is 111 South Street, Anywhere, MD 21212.

Sign Off (finish later)

Next

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0822**

Print your reentry number and receipt

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You have completed the initial portion of your disability appeal. You have provided enough information to obtain a receipt and reentry number. Your reentry number allows you to continue the appeal later if you cannot proceed at this time.

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Your reentry number is: 74549174

To continue with this appeal later, go to www.socialsecurity.gov/disability/appeal and select "Go Back to the Appeal You Already Started."

Guard your reentry number carefully because you must have it to reenter the appeal. Do not put it where an unauthorized person can see it.

Social Security employees cannot access your reentry number.

1. Print your reentry number and receipt.

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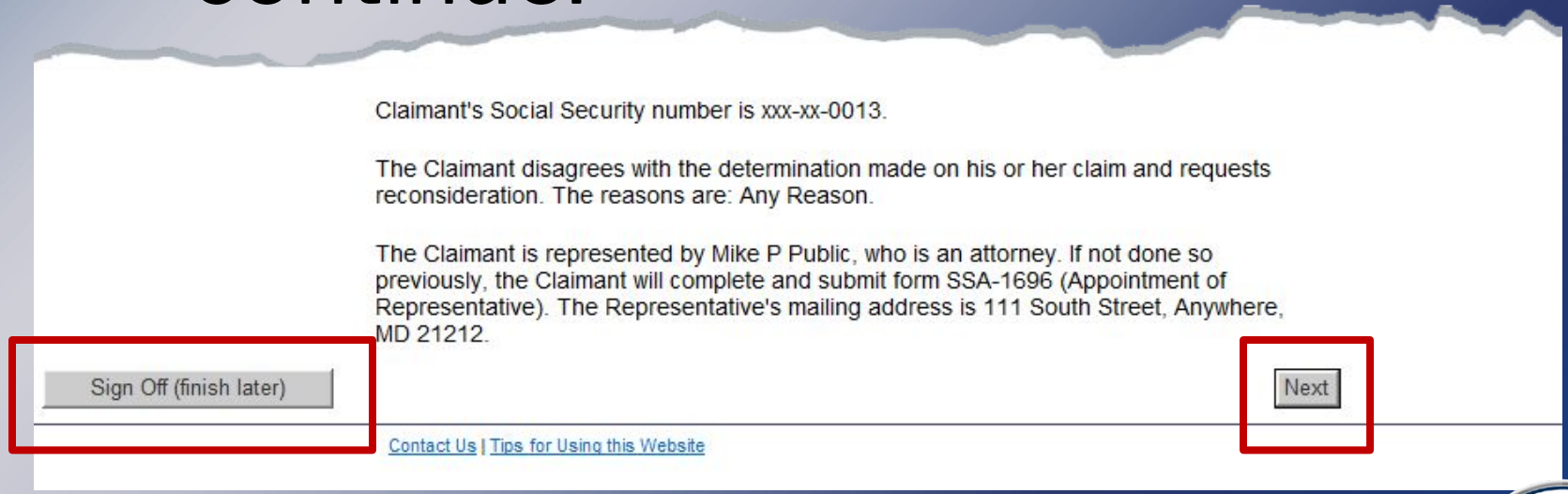
2. Guard your reentry number carefully.

1. Print your reentry number and receipt.
2. Guard your reentry number carefully.
3. The medical information we gather is **necessary**.

4. Use the “Sign Off (finish later)” button to come back another time or select “Next” to continue.



Three Sections of the Disability Report

- About You
- Medical History
- Review and Send

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0823**

About you: general information

OMB No. 0960-0144
Paperwork Reduction Act

Your privacy is important. For details about our use of your information, we encourage you to read our Privacy Act Statement.

The name and address were entered on the Appeal Request.

Name: **John G Public**

(First, Middle, Last)

* **Address:**

* **(Street Address 1)** 13 Nophat Ln

(Street Address 2)

(Street Address 3)

(Street Address 4)

***(City, State, Zip Code)** Owings Mills MD 21117

Telephone Number: 410-555-1213

Extension:

We need to know how to contact or leave a message for the claimant.

- (•) **This is the claimant's phone number.**
- ( ) **The claimant does not have a phone, but you can leave a message at this number.**

Email Address:

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0823**

About you: someone we can contact about your conditions

Please tell us about someone else, other than your doctor or health care provider, whom we can contact to help with your appeal if necessary. Doctors and hospitals may not have a complete picture of how your conditions affect your daily life and your work. We may need to talk with someone who knows you and knows about your conditions.

If you are completing this for a child, please give us your name and address or that of the person who is giving you the information.

*** Contact Person's Name:**

(First, Middle Initial, Last)

Suffix (if any)

Relationship to You:

- Husband or Wife
- Mother
- Father
- Sister
- Brother
- Grandparent
- Child
- Aunt
- Uncle
- Cousin
- Stepmother
- Stepfather
- Neighbor
- Friend
- Significant Other
- Other (such as Social Worker, Attorney, Legal Representative) :

- Aunt
- Uncle
- Cousin
- Stepmother
- Stepfather
- Neighbor
- Friend
- Significant Other
- Other (such as Social Worker, Attorney, Legal Representative) :

* **Address:**

Please provide this contact's complete address, including apartment number if applicable. Please do NOT use punctuation; for example, no periods or commas. Example: 528 Dawn St Apt 101

Check if same as John Public's address

* (Street Address 1)

(Street Address 2)

(Street Address 3)

* (City, State, ZIP)

Daytime Phone Number:

Check if same as John Public's phone number

We need to be able to contact this person during the day.

Extension:

Sign Off (finish later) | Add Another Contact | Previous | Next

Contact Us | Tips for Using this Website

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0012**

About you: updated information

Please tell us about changes in your illnesses, injuries, or conditions **since you last completed a Disability Report**. Look at the medical decision notice you received in the mail if you are not sure what you already told us. If you previously filed an Internet report, please refer to any pages you saved or printed.

You must answer all of the questions on this page before you can continue. We will ask you to explain some of your "yes" answers.

Your Conditions Since You Last Completed a Disability Report:

* **Has there been any change (for better or worse) in any of your conditions?**

Examples: blood pressure has gotten higher, asthma is worse

○ **Yes** ○ **No**

* **Do you have any new physical or mental limitations as a result of your conditions?**

Examples: can't walk without a walker now; can't take gym class

○ **Yes** ○ **No**

Social Security Online

Disability Appeal

www.socialsecurity.gov

About You | Medical History | Review and Send

Name: **John G Public**
SSN: **xxx-xx-0822**

About you: summary

Please review the information that you gave us earlier and make sure it is correct. To go back to any item to make changes or corrections, select the Edit button. If you would like to make an addition, select the Add button.

This page will print in a printer friendly format.

Note: Because of space limitations, this summary will show only the first 100 characters of the typed descriptions you gave us. However, everything you told us will be included in the report that you submit to Social Security.

Information About You

General Information

Edit

John G Public

555 Main Street
Anywhere, MD 21087

People We Can Contact About Your Condition

Add Another Contact

About Your Conditions Since You Last Completed a Disability Report

Changes in Your Conditions

Edit

These changes began January 2004
Description of changes to your condition: Back pain is worse. Hard to stand and move around.

New Physical or Mental Limitations

Social Security Online

Disability Appeal

www.socialsecurity.gov

About You | Medical History | Review and Send

Name: **John G Public**
SSN: **xxx-xx-0822**

Medical history: treatments and medicines

Please tell us about hospital visits, doctor visits, medicines, and tests **since you last gave us medical information**. If you are not sure what information you've already given us, look at the medical decision notice you received in the mail. If you previously filed an Internet report, please refer to any summary pages you printed.

Treatments and Tests Since You Last Gave Us Medical Information:

Be sure to include any doctors who prescribed medicines that you are currently taking as well as those who sent you for tests.

* **Have you seen or will you see a doctor, hospital, clinic, or anyone else for your conditions?**	○ Yes ○ No
* **Have you seen or will you see a doctor, hospital, clinic, or anyone else for mental or emotional problems?**	○ Yes ○ No
* **Have you had any medical tests, or do you have any tests scheduled for your conditions?**	○ Yes ○ No

Current medicines:

* **Are you taking any prescription or over-the-counter medicines for your conditions?**	○ Yes ○ No

Social Security Online

Disability Appeal

www.socialsecurity.gov

About You | Medical History | Review and Send

Name: **John G Public**
SSN: **xxx-xx-0822**

Medical history: more about Dr. Stephen Miles

Please give us enough information to contact Dr. Stephen Miles. If you do not have all the information, give us as much as you can. Missing or incomplete information can delay us in getting your records or we may not be able to get them at all. If you have more than one doctor, we'll ask about the others later.

*** Name of Doctor:** Dr. | Stephen | Miles

(First, Last)

HMO, Clinic, or Office Name: Jackson County Clinic

(If applicable)

*** Address:**

Check the phone book, your appointment card, or billing statement for the address.

Please include ZIP code, since it helps us contact Dr. Stephen Miles more quickly. Please do NOT use punctuation; for example, no periods or commas.

(Street Address 1) 5285 E Jackson St

(Street Address 2)

(Street Address 3)

*** (City, State, ZIP)** Medford | MD | 21114

Social Security Online

Disability Appeal

www.socialsecurity.gov

About You | Medical History | Review and Send

Name: **John G Public**
SSN: **xxx-xx-0822**

Review and send: summary

Please review your answers below. Select "Edit" if you need to make a change.

You can print or save a copy for your records.

About You Summary

Information About You

General Information

Edit John G Public

555 Main Street
Anywhere, MD 21087

People We Can Contact About Your Condition

Add Another Contact

About Your Conditions Since You Last Completed a Disability Report

Changes in Your Conditions

Edit These changes began January 2004
Description of changes to your condition: Back pain is worse. Hard to stand and move around.

New Physical or Mental Limitations

Edit Description of new physical or mental limitations: Back pain is worse. Hard to stand and move around.

New Conditions

Edit The new condition began January 2004
Description of new condition: Back pain is worse. Hard to stand and move around.

About Your Activities

Edit Description of changes to daily activities: Hard to stand and move around. Have to lay down a lot.
Description of ability to care for personal needs: Cannot go grocery shopping. Hurts to move

Social Security Online

Disability Appeal

www.socialsecurity.gov

About You | Medical History | Review and Send

Name: **John G Public**
SSN: **xxx-xx-0822**

Review and send: summary

Please review your answers below. Select "Edit" if you need to make a change.

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About You Summary

Information About You

General Information

Edit

John G Public

555 Main Street
Anywhere, MD 21087

People We Can Contact About Your Condition

Add Another Contact

About Your Conditions Since You Last Completed a Disability Report

Changes in Your Conditions

Edit

These changes began January 2004
Description of changes to your condition: Back pain is worse. Hard to stand and move around.

New Physical or Mental Limitations

Edit

Description of new physical or mental limitations: Back pain is worse. Hard to stand and move around.

New Conditions

Edit

The new condition began January 2004
Description of new condition: Back pain is worse. Hard to stand and move around.

About Your Activities

Edit

Description of changes to daily activities: Hard to stand and move around. Have to lay down a lot.
Description of ability to care for personal needs: Cannot go grocery shopping. Hurts to move

Social Security Online

Disability Appeal

www.socialsecurity.gov

About You | Medical History | Review and Send

Name: **John G Public**
SSN: **xxx-xx-0822**

Review and send: additional remarks

You may provide comments or any additional information (such as doctors, hospitals, or medicines) below.

Please enter any additional remarks:

2000 characters maximum. This is about 40 lines of typing or about 320 words.

Count Characters You have entered 0 characters

* **Information About the Person Completing this Report**

- John Public completed this report
- June Public completed this report
- Someone else completed this report

If you completed this report for John Public and you are not June Public, please provide the information requested below. Skip this part if you completed the report for yourself.

Name: **Suffix (if any)**

(First, Middle Initial, Last)

Address:

(Street Address 1)

(Street Address 2)

(Street Address 3)

(City, State, ZIP)

Email Address (Optional)

Relationship to Disabled Person

Daytime Telephone Number **Extension:**

Sign Off (finish later) Previous Next

Contact Us | Tips for Using this Website

Social Security Online

Disability Appeal

www.socialsecurity.gov

About You | Medical History | Review and Send

Name: **John G Public**
SSN: **xxx-xx-0822**

Review and send: submit this appeal

When you are ready, use "Submit" to complete your appeal.

If you need to make changes, select "Previous" to go back.

IMPORTANT: You will NOT be able to come back to this appeal once you select "Submit".

Sign Off (finish later) | Previous | Submit

Contact Us | Tips for Using this Website

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Disability Appeal

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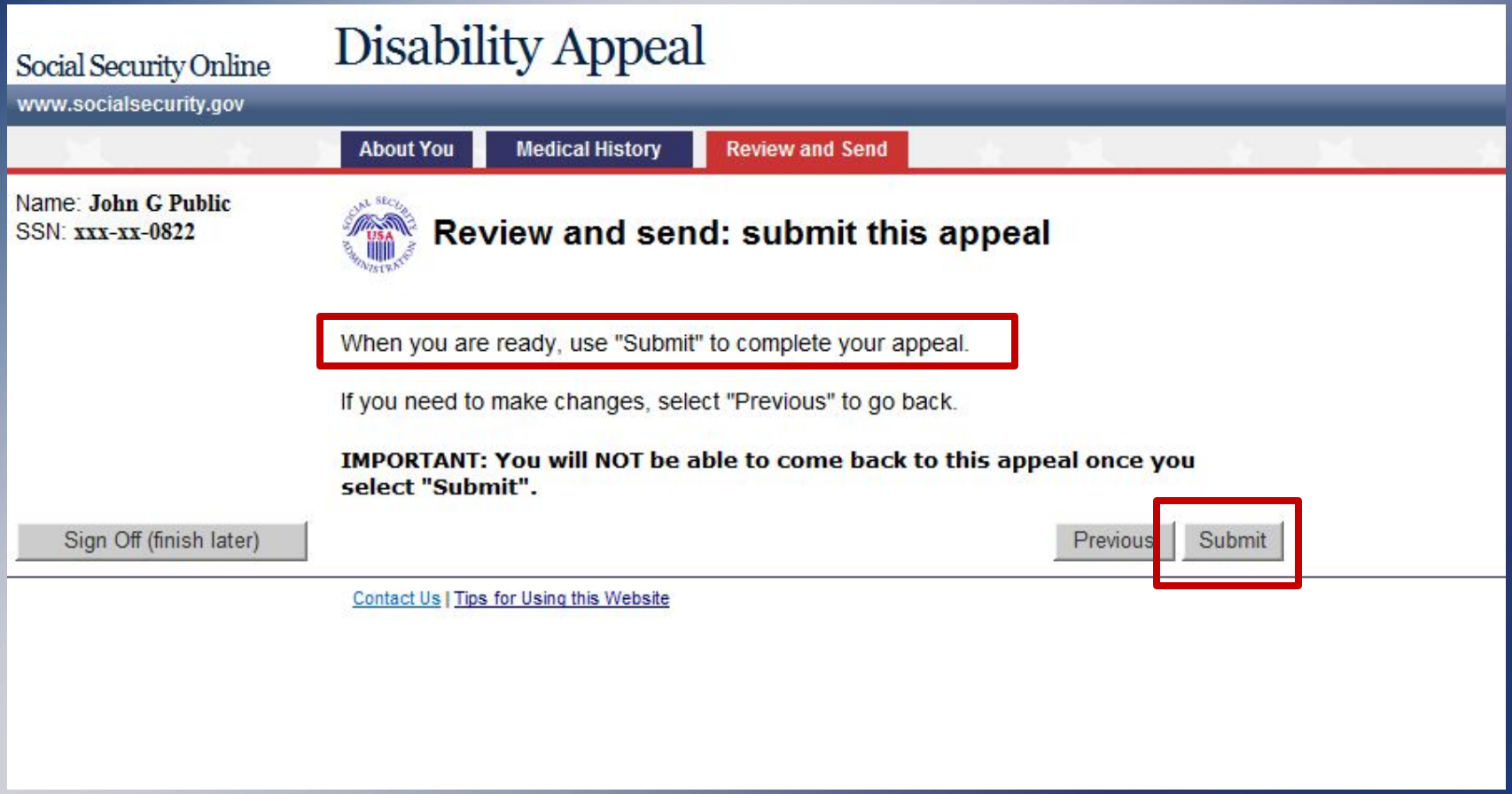
Contact Us | Tips for Using this Website


Social Security Online
Disability Appeal
www.socialsecurity.gov
About You
Medical History
Review and Send
Name: John G Public
SSN: xxx-xx-0822
Review and send: submit this appeal
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Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0822**

Confirmation and printing

Thank you. You can print your receipt for disability appeal report for your records.

Although you have submitted your disability appeal online, we still need a few items from you.

Please print and complete the following:

1. Cover sheet.
2. Medical Release Form (Authorization to Disclose information to the Social Security Administration)
   (View instructions for completing this form.)
3. If you have not already done so, print and complete Form SSA-1696 (Appointment of Representative)
4. Print and complete Form HA-4608 (Waiver of Your Right to Personal Appearance before an ALJ)

Mail your cover sheet and completed form(s) to any Social Security Office.

If you are unable to print:

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You can also try printing these forms later. Go to www.socialsecurity.gov and enter the form number (i.e. 827) in the search box.

Finish

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
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Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0052**

Cover sheet

Date: February 9, 2012

John Public's contact information:

555 Main Street
Anywhere, MD 21087
(410) 555-1212

Name of person completing this disability report: John Public

The following items are attached (check all that apply):

___Medical Release (Authorization to Disclose information to the Social Security Administration)
___Form HA-4608 (Waiver of Right to Personal Appearance)
___Other medical evidence
___Other (Please list below.)

_____

_____

Mail completed forms to any Social Security Office

John Public's local Social Security office is located at:

SOCIAL SECURITY ADMINISTRATION
110 WEST ROAD
SUITE 500 CORP CENTER
TOWSON, MD 21204
(866) 614-4758

Close this window to return to the appeal process.

Social Security Online

Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0052**

Cover sheet

Date: February 9, 2012

John Public's contact information:

555 Main Street
Anywhere, MD 21087
(410) 555-1212

Name of person completing this disability report: John Public

The following items are attached (check all that apply):

✓ Medical Release (Authorization to Disclose information to the Social Security Administration)
___ Form HA-4608 (Waiver of Right to Personal Appearance)
___ Other medical evidence
✓ Other (Please list below.)

_____

_____

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SOCIAL SECURITY ADMINISTRATION
110 WEST ROAD
SUITE 500 CORP CENTER
TOWSON, MD 21204
(866) 614-4758

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Disability Appeal

www.socialsecurity.gov

Name: **John G Public**
SSN: **xxx-xx-0052**

Cover sheet

Date: February 9, 2012

John Public's contact information:

555 Main Street
Anywhere, MD 21087
(410) 555-1212

Name of person completing this disability report: John Public

The following items are attached (check all that apply):

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Disability Appeal

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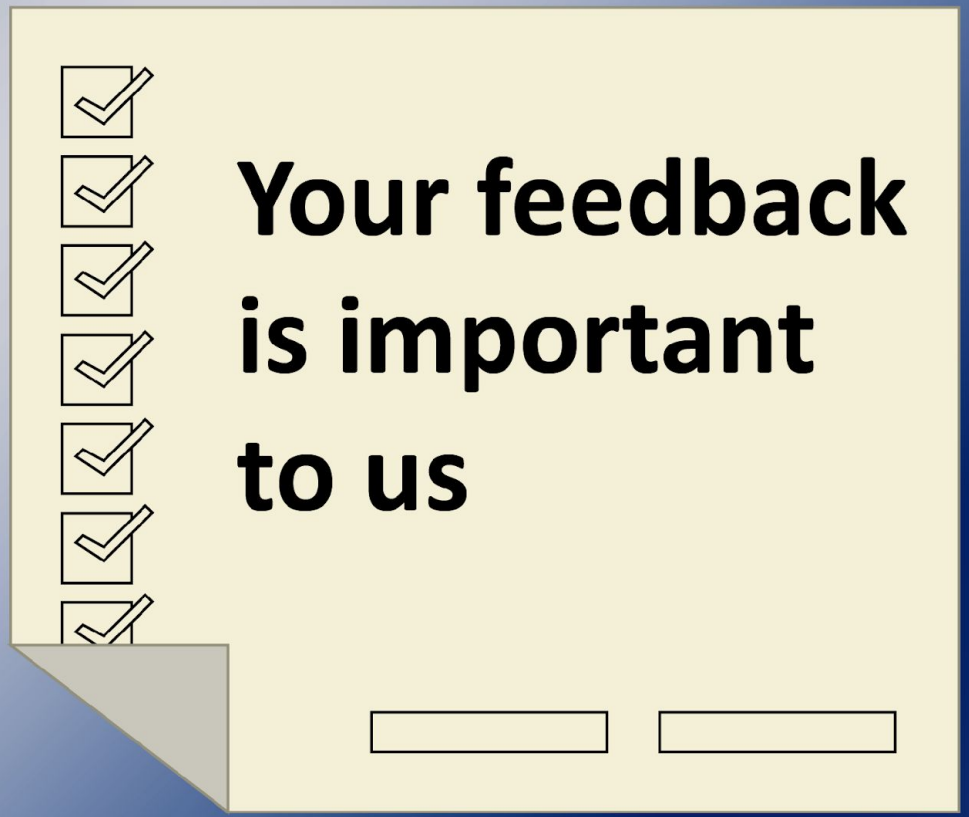
Need Help? Contact Us:

Monday - Friday
7 am – 7 pm (local) at

1-800-772-1213 or
TTY 1-800-325-0778

Please take a few minutes to fill out our brief survey

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