Date:

Social Security

Representative's Section

Please Circle SSI/SSDI

Name: ______________________________
Address: ______________________________
____

Phone No: ______________________________

Diagnosis/Complaint: ________
____
____
____

Main Representative (if different from above) ______________________________

Claimant's Section

Name: ______________________________
Address: ______________________________
____

Phone No: ______________________________
Fax No: ______________________________

Date of Birth: ________________

SSN No: ________________

Denial Date: ____________

I request a Hearing before an Administrative Law Judge. I disagree with the determination made on my claim because ______________________________
____
____
____
____

Do you have additional evidence to submit? ☐ Yes ☐ No
Medical Records Yes No Other: ______________________________
Do you wish to appear at the hearing? Yes No If No, why? ________________

Medical Treatment

List the name, address, and telephone number of each physician, psychiatrist or other medical care provider who has examined, treated or interviewed you relating to your current disability, complete the following:

(a) Physician's name ______________________________

Address ______________________________

Telephone number ______________________________

Diagnosis (if received) ______________________________

Medications/Treatment prescribed ______________________________

(b) Physician's name ____

Address ____

Telephone number ____

Diagnosis (if received) ____

Medications/Treatment prescribed ____________________________

(c) Physician's name ____

Address ____

Telephone number ____

Diagnosis (if received) ____

Medications/Treatment prescribed ____________________________

(d) Physician's name ____

Address ____

Telephone number ____

Diagnosis (if received) ____

Medications/Treatment prescribed ____________________________

(e) Physician's name ____

Address ____

Telephone number ____

Diagnosis (if received) ____

Medications/Treatment prescribed ____________________________

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