IAPPEALS MEDICAL SCREEN SHOTS

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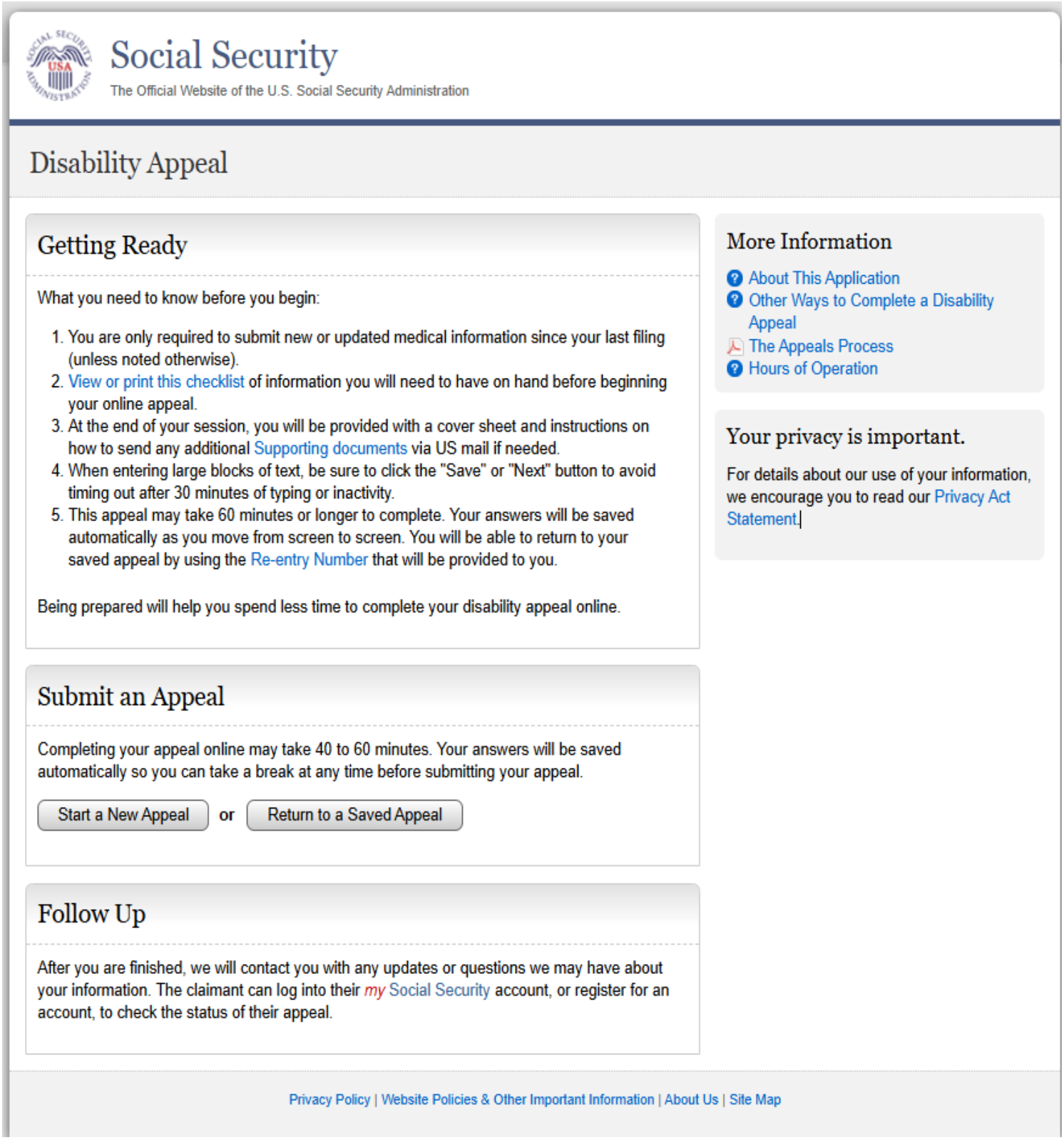
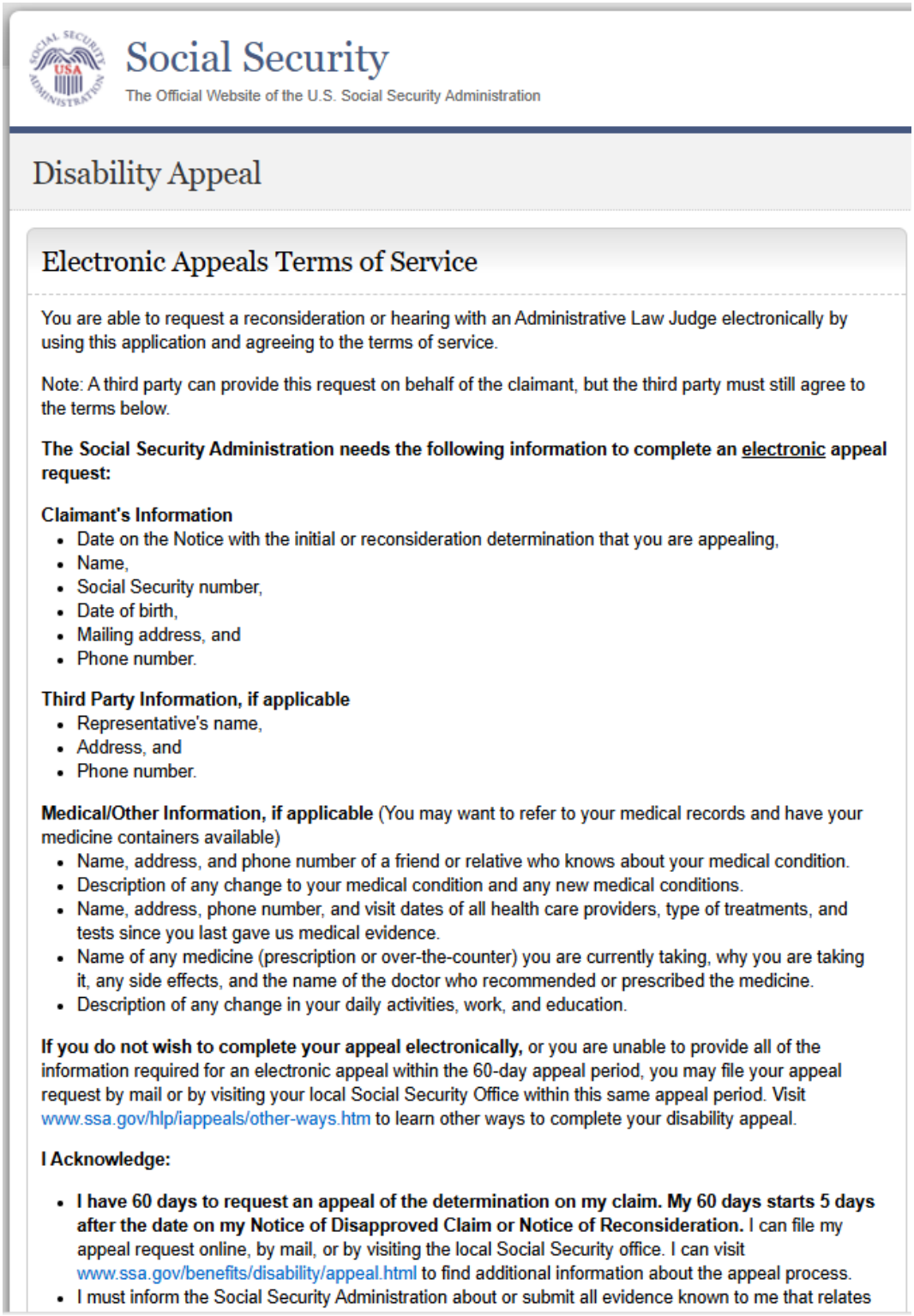
Section: Entry, Restart, and Exit Pages

Welcome page (Wlcm001)



Electronic Appeals Terms of Service (Tos001)



Social Security

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

Disability Appeal

Electronic Appeals Terms of Service

You are able to request a reconsideration or hearing with an Administrative Law Judge electronically by using this application and agreeing to the terms of service.

Note: A third party can provide this request on behalf of the claimant, but the third party must still agree to the terms below.

The Social Security Administration needs the following information to complete an electronic appeal request:

Claimant's Information

- Date on the Notice with the initial or reconsideration determination that you are appealing,
- Name,
- Social Security number,
- Date of birth,
- Mailing address, and
- Phone number.

Third Party Information, if applicable

- Representative's name,
- Address, and
- Phone number.

Medical/Other Information, if applicable (You may want to refer to your medical records and have your medicine containers available)

- Name, address, and phone number of a friend or relative who knows about your medical condition.
- Description of any change to your medical condition and any new medical conditions.
- Name, address, phone number, and visit dates of all health care providers, type of treatments, and tests since you last gave us medical evidence.
- Name of any medicine (prescription or over-the-counter) you are currently taking, why you are taking it, any side effects, and the name of the doctor who recommended or prescribed the medicine.
- Description of any change in your daily activities, work, and education.

If you do not wish to complete your appeal electronically, or you are unable to provide all of the information required for an electronic appeal within the 60-day appeal period, you may file your appeal request by mail or by visiting your local Social Security Office within this same appeal period. Visit www.ssa.gov/hlp/iappeals/other-ways.htm to learn other ways to complete your disability appeal.

I Acknowledge:

- **I have 60 days to request an appeal of the determination on my claim. My 60 days starts 5 days after the date on my Notice of Disapproved Claim or Notice of Reconsideration.** I can file my appeal request online, by mail, or by visiting the local Social Security office. I can visit www.ssa.gov/benefits/disability/appeal.html to find additional information about the appeal process.
- I must inform the Social Security Administration about or submit all evidence known to me that relates

statements from medical sources about what I can still do despite my impairment(s).

- If I wish to submit evidence after I have submitted my appeal request, I can use www.ssa.gov/locator to find my local Social Security office and its business hours. I understand that in order for the Social Security Administration to consider my evidence, I must submit the evidence before the Social Security Administration makes a determination or decision on my appeal request.
- Appeal Level
  - Request for Reconsideration - I understand that if I have evidence to submit, but I am not able to submit it at the time I submit my appeal request, I should write, 'I have additional evidence to submit that is not electronic' in the 'I do not agree with the determination made on the above claim and request reconsideration. My reasons are:' section.
  - If the Social Security Administration sends me a notice that requests the evidence, I understand that I have 15 days to submit it before the Social Security Administration will start to process my request for reconsideration. I understand that once the 15 days expires, I still must inform the Social Security Administration about or submit any additional evidence.
  - Request for Hearing by Administrative Law Judge - I understand that if I have additional evidence to submit, but I am not able to submit it at the time I submit my appeal request, I can indicate on my appeal request that I have more evidence and can provide the name and sources of the additional evidence. I understand that I must inform the Social Security Administration about or submit any additional evidence no later than 5 business days before the date of my hearing.

- I must select the 'Submit' button within the Submit tab to file my appeal request with the Social Security Administration. **If I exit the application before selecting the "Submit" button, my appeal request will not be completed or processed.**
- Once I submit my appeal request electronically:
  - I will receive an on-screen confirmation that my appeal request has been submitted. I will also receive an email confirmation if an email address was provided.
  - The Social Security Administration will provide a cover sheet, which I can print and use to submit any evidence that I want the Social Security Administration to include with my appeal request.
  - If I indicated in my appeal request that I have additional evidence or the Social Security Administration needs additional information, a Social Security representative may contact me by email, phone, or mail.

- I **can** re-enter this application if:
  - I received a Re-entry number;
  - I do not submit my current appeal request; and
  - My appeal period has not expired.

- I **cannot** re-enter this application if:
  - I do not receive a re-entry number;
  - The appeal period has expired; or
  - I already submitted an appeal request on the determination or that I am attempting to appeal.

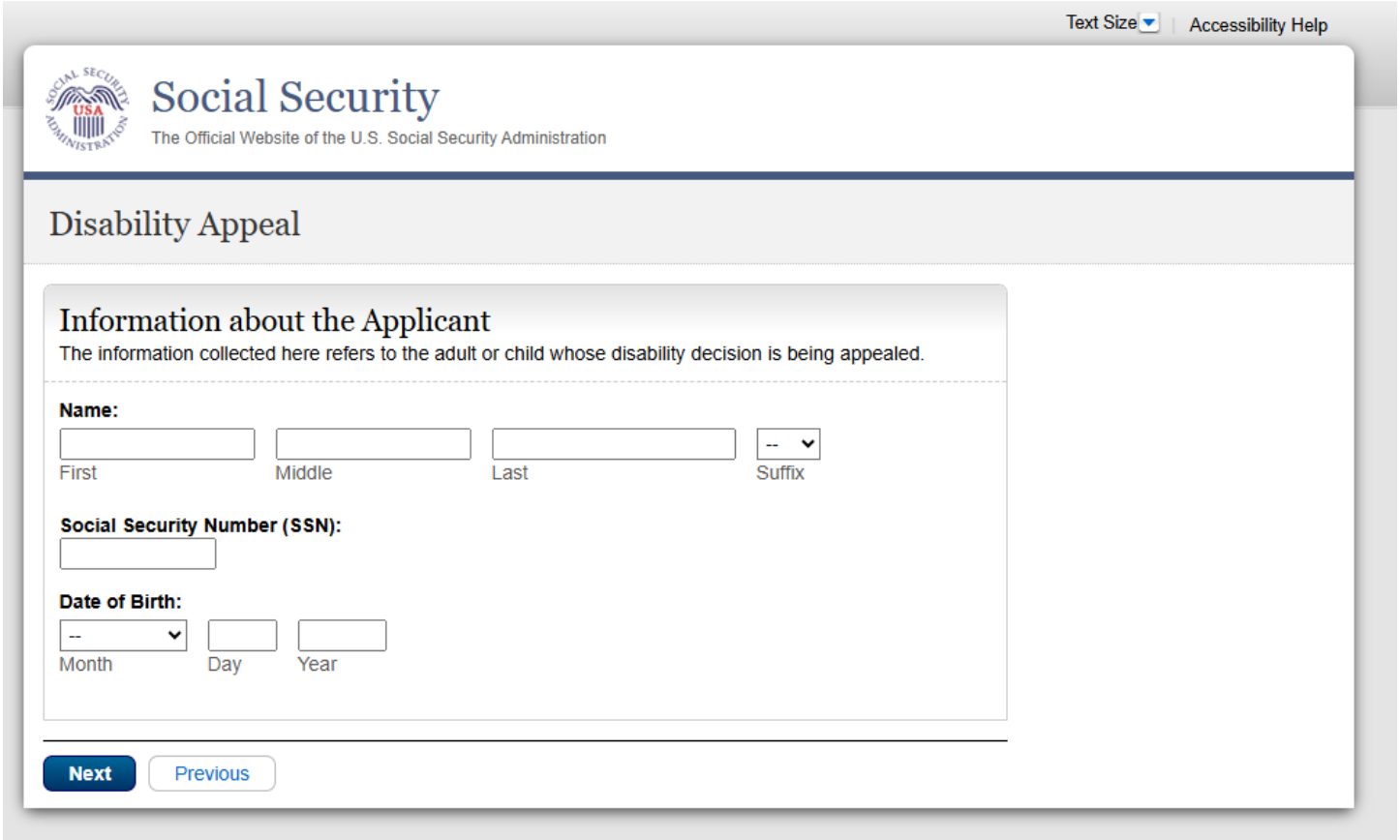
- If I want to add additional information to or change submitted information, I will mail, fax, or deliver paper copies of my evidence to my local Social Security office.
- I can obtain a receipt for my appeal request by accessing my Social Security account at www.socialsecurity.gov/myaccount , or by contacting my local Social Security office.

I understand that I may be subject to criminal or civil penalties, or both, if I provide false or misleading statements, engage in unauthorized use of this system, or otherwise misuse this system.

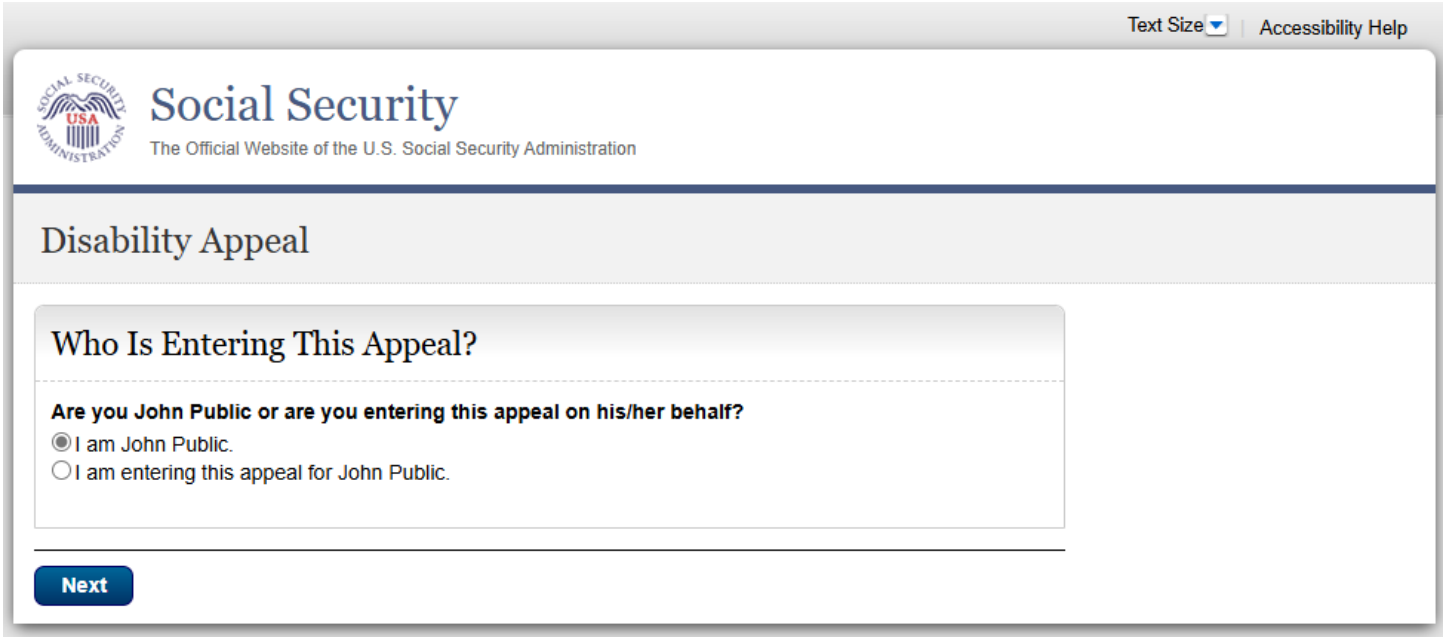
☐ I agree to the Terms of Service.

Next Exit

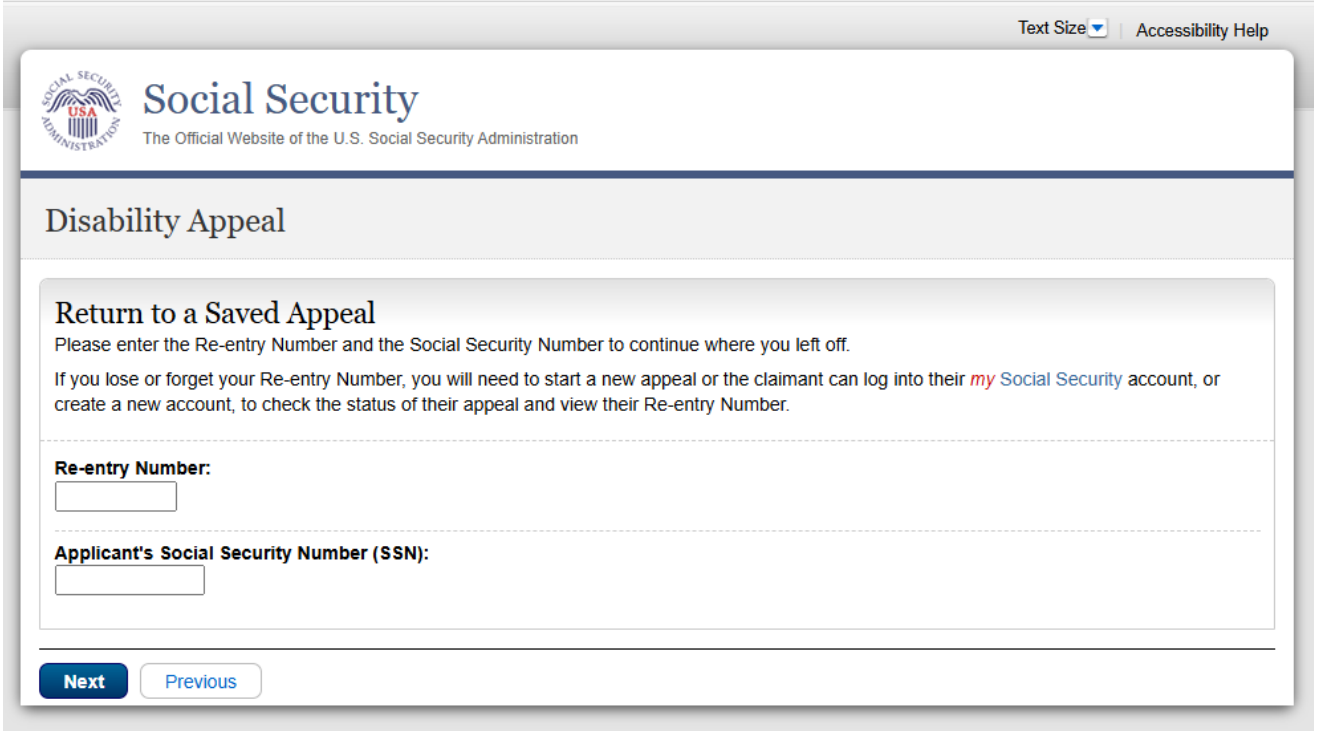
Screening: Information about the Applicant (Scrn001)



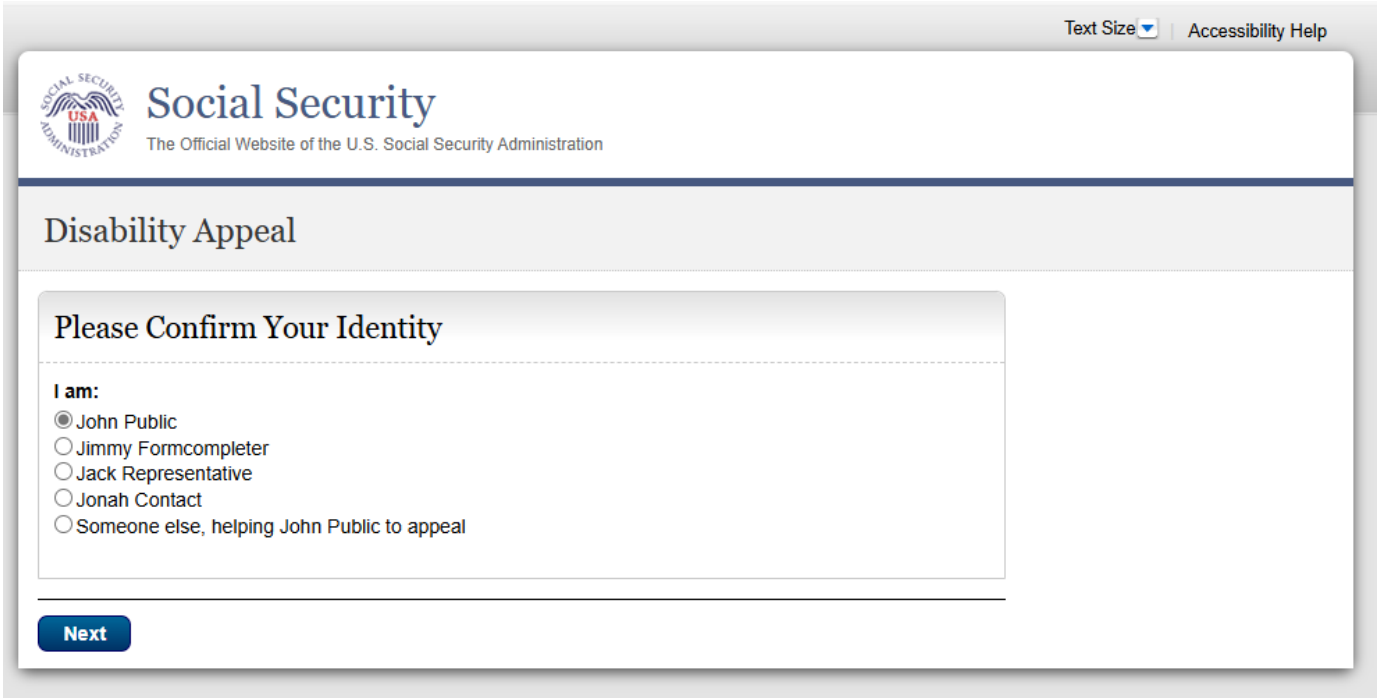
Who is entering this appeal (Entr001)

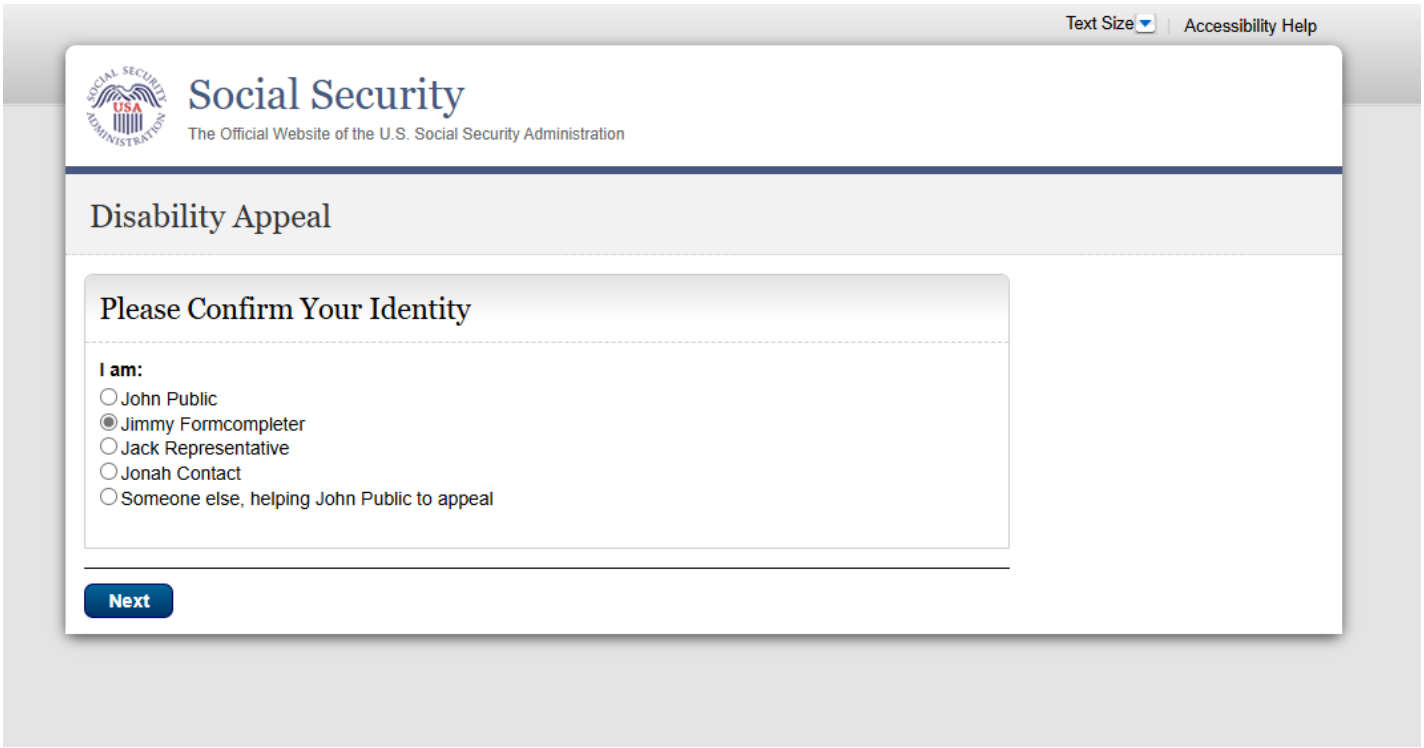


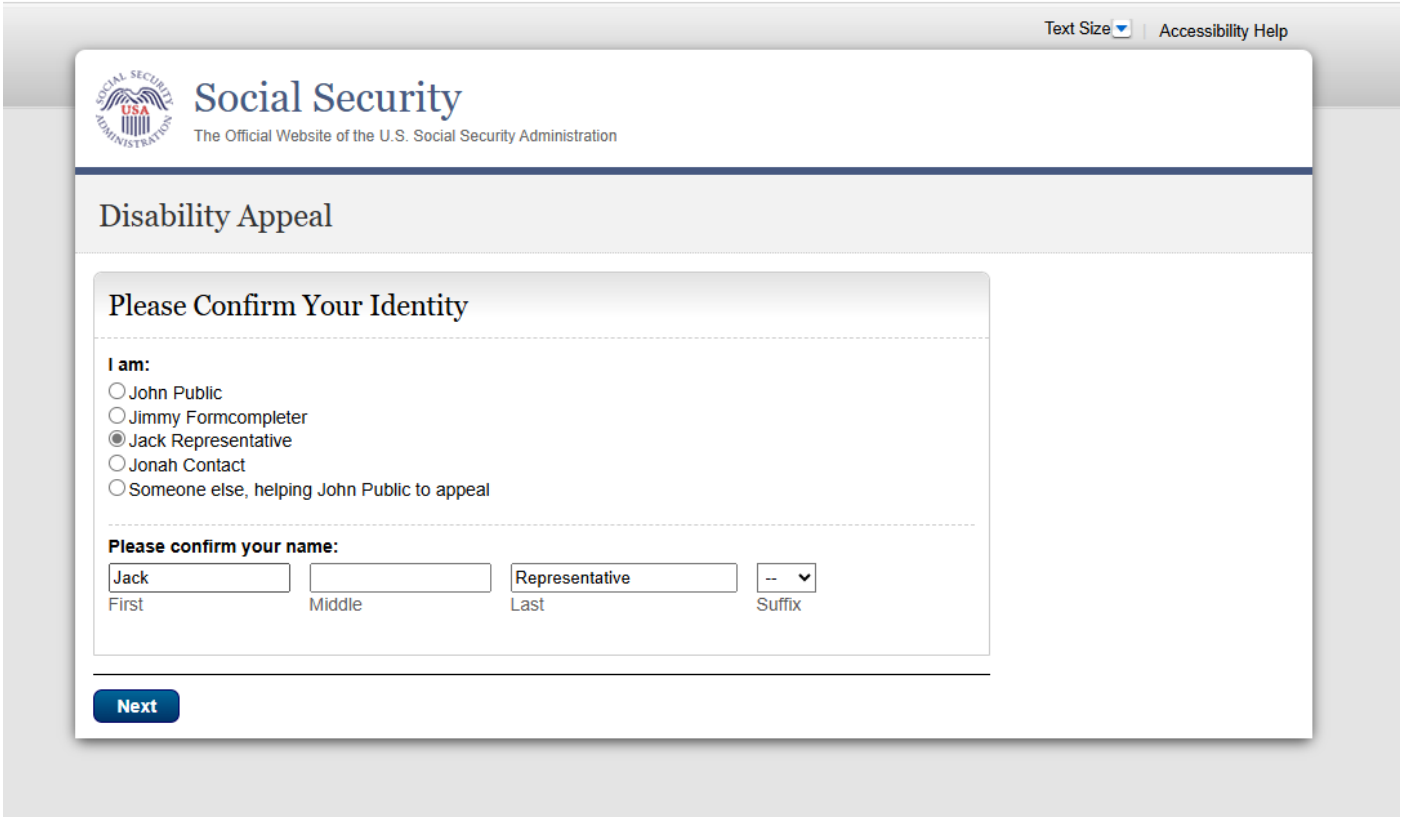
Return to Saved appeal (Rtrn001)



Confirm your identity (Cfid001)






Text Size
Accessibility Help
Social Security
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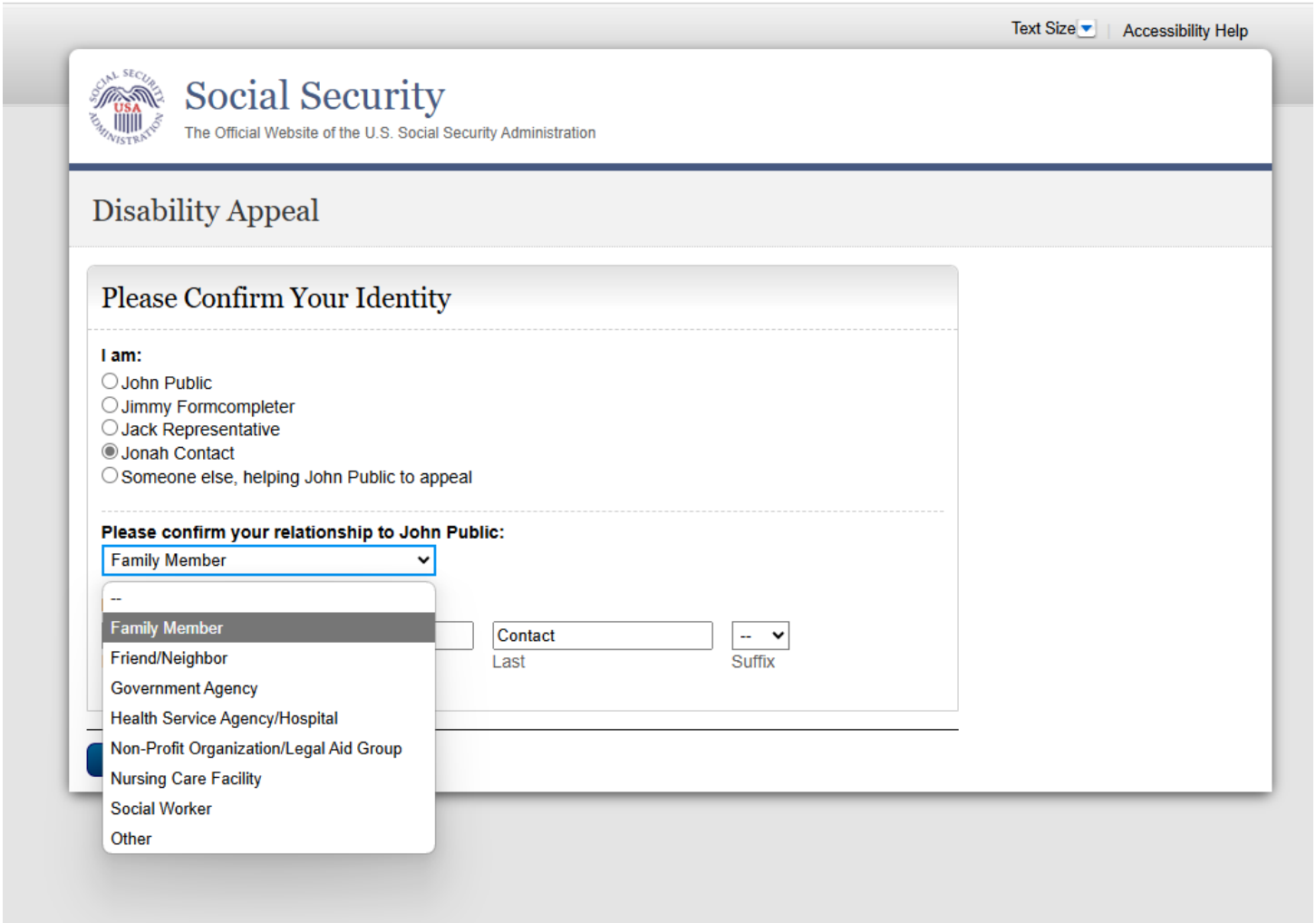
Disability Appeal
Please Confirm Your Identity
I am:
John Public
Jimmy Formcompleter
Jack Representative
Jonah Contact
Someone else, helping John Public to appeal
Please confirm your name:
Jack
First
Middle
Representative
Last
--
Suffix
Next


Text Size
Accessibility Help
Social Security
The Official Website of the U.S. Social Security Administration
Disability Appeal
Please Confirm Your Identity
I am:
John Public
Jimmy Formcompleter
Jack Representative
Jonah Contact
Someone else, helping John Public to appeal
Please confirm your relationship to John Public:
Family Member
--
Family Member
Friend/Neighbor
Government Agency
Health Service Agency/Hospital
Non-Profit Organization/Legal Aid Group
Nursing Care Facility
Social Worker
Other
Contact
Last
--
Suffix

AppIsRe/Cfid001.html

Text Size | Accessibility Help

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Disability Appeal

Please Confirm Your Identity

I am:

- John Public
- Jimmy Formcompleter
- Jack Representative
- Jonah Contact
- Someone else, helping John Public to appeal

What is your relationship to John Public?

--

-- Appointed Representative (Attorney) or Staff
Appointed Representative (Non-Attorney) or Staff
Family Member
Friend/Neighbor
Government Agency
Health Service Agency/Hospital
Non-Profit Organization/Legal Aid Group
Nursing Care Facility
Social Worker
Other

ast Suffix

Add Line

ZIP Code:

Your Daytime Phone Number:

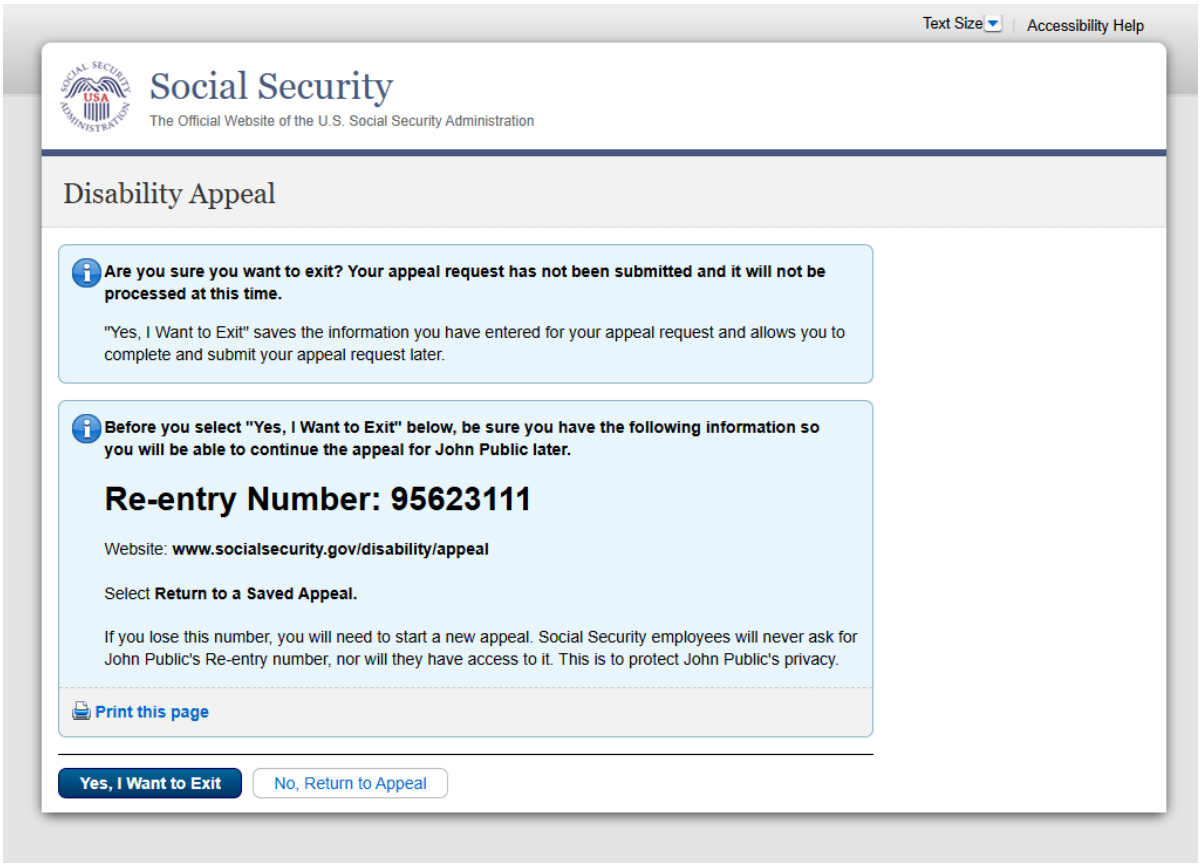
U.S. International

10-digit Number Ext

Next

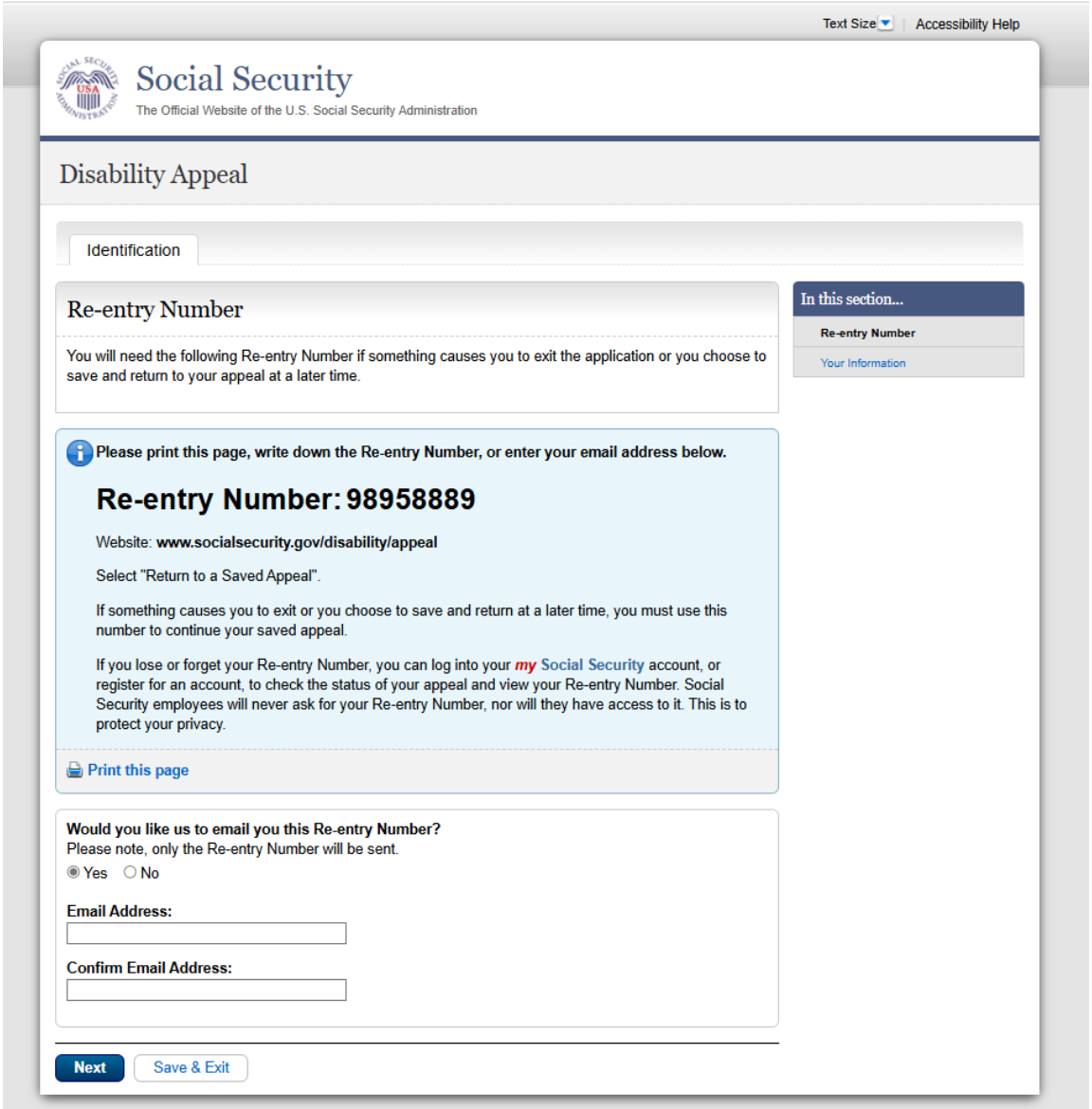
1st Party: Exiting the Application (Exit001-1)

3rd Party: Exiting the Application (Exit001-3)

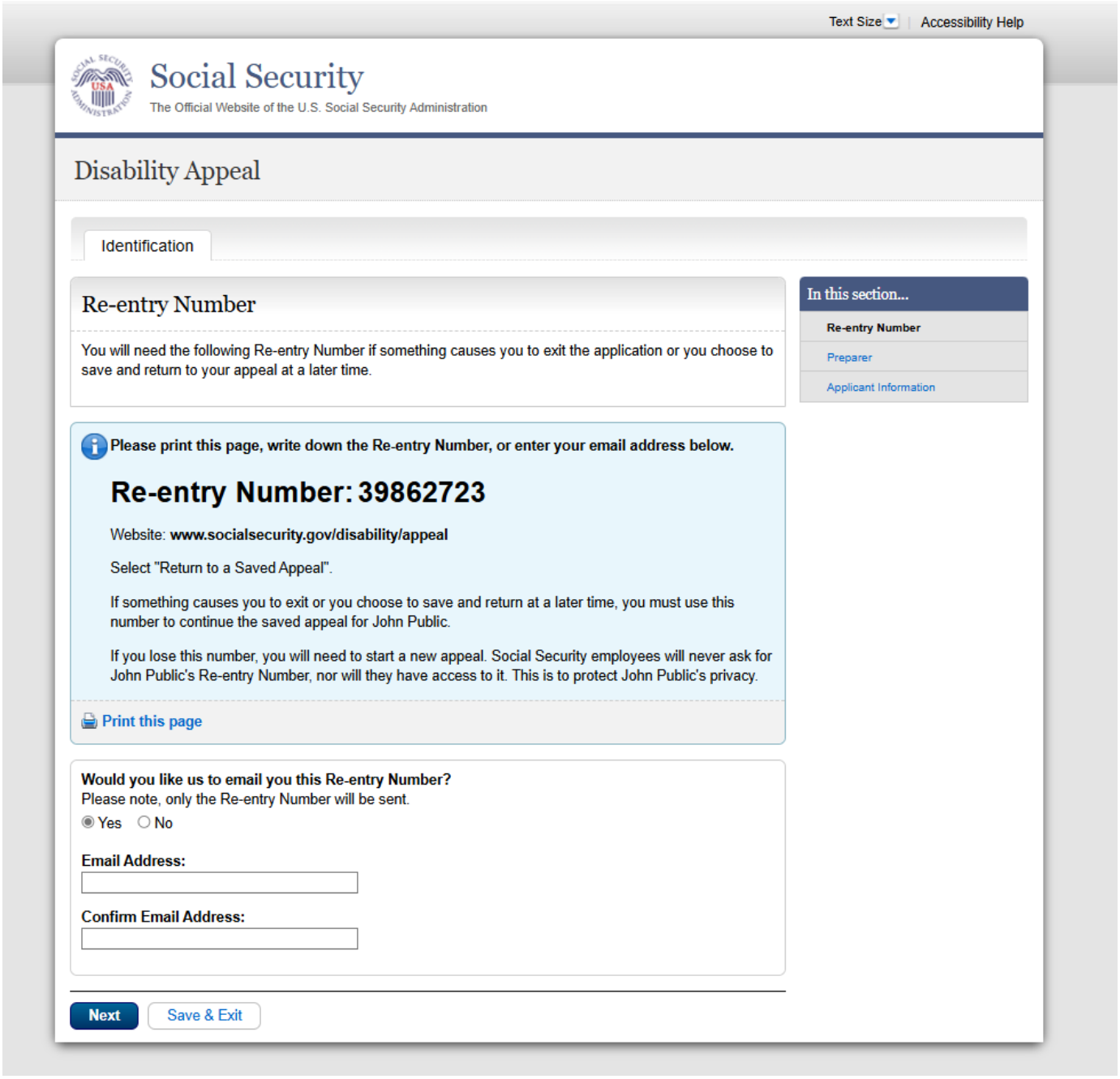


Section: Identification Pages

1st Party: Re-entry Number (Rnty001-1)

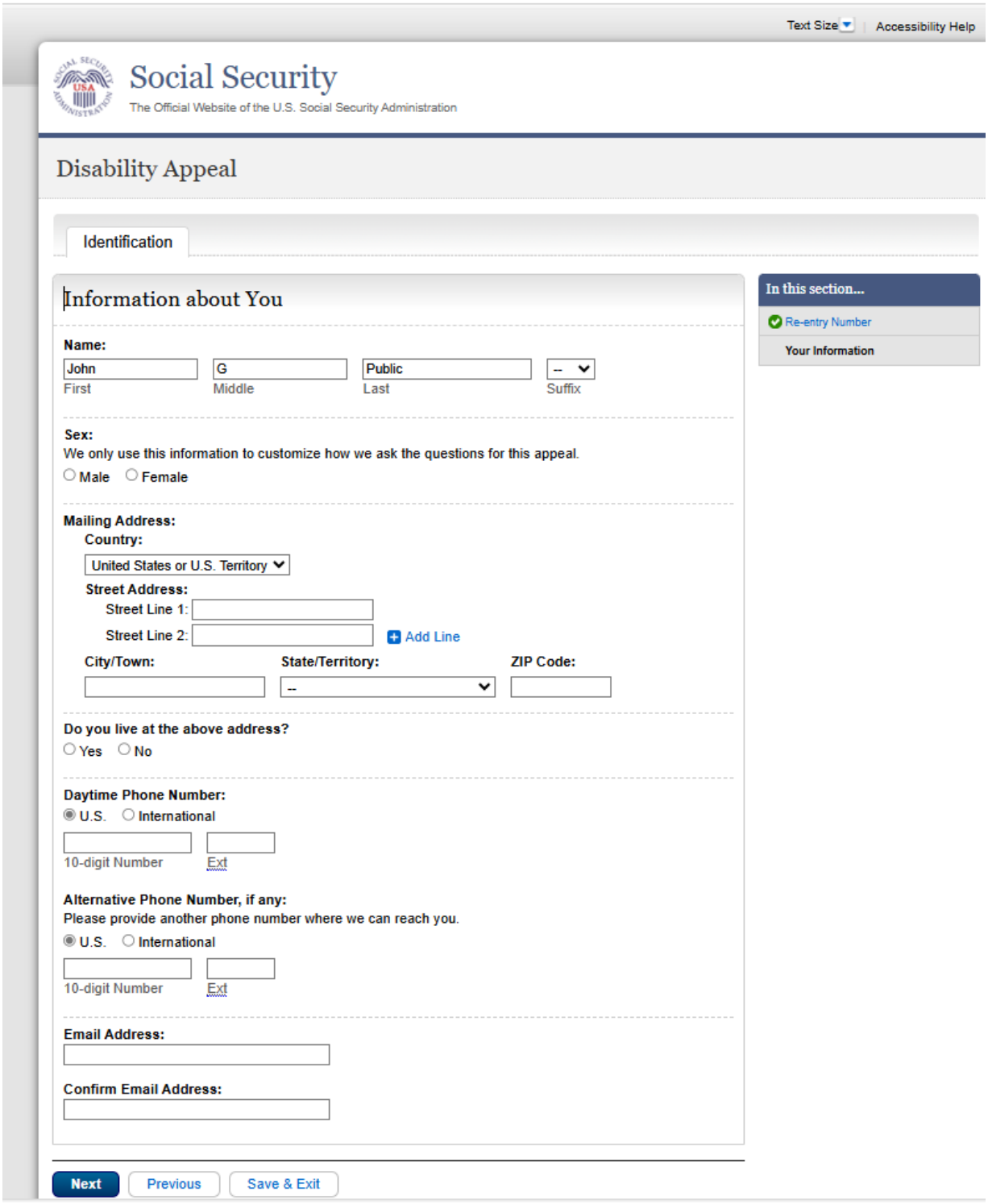


3rd Party: Re-entry Number (Rnty001-3)

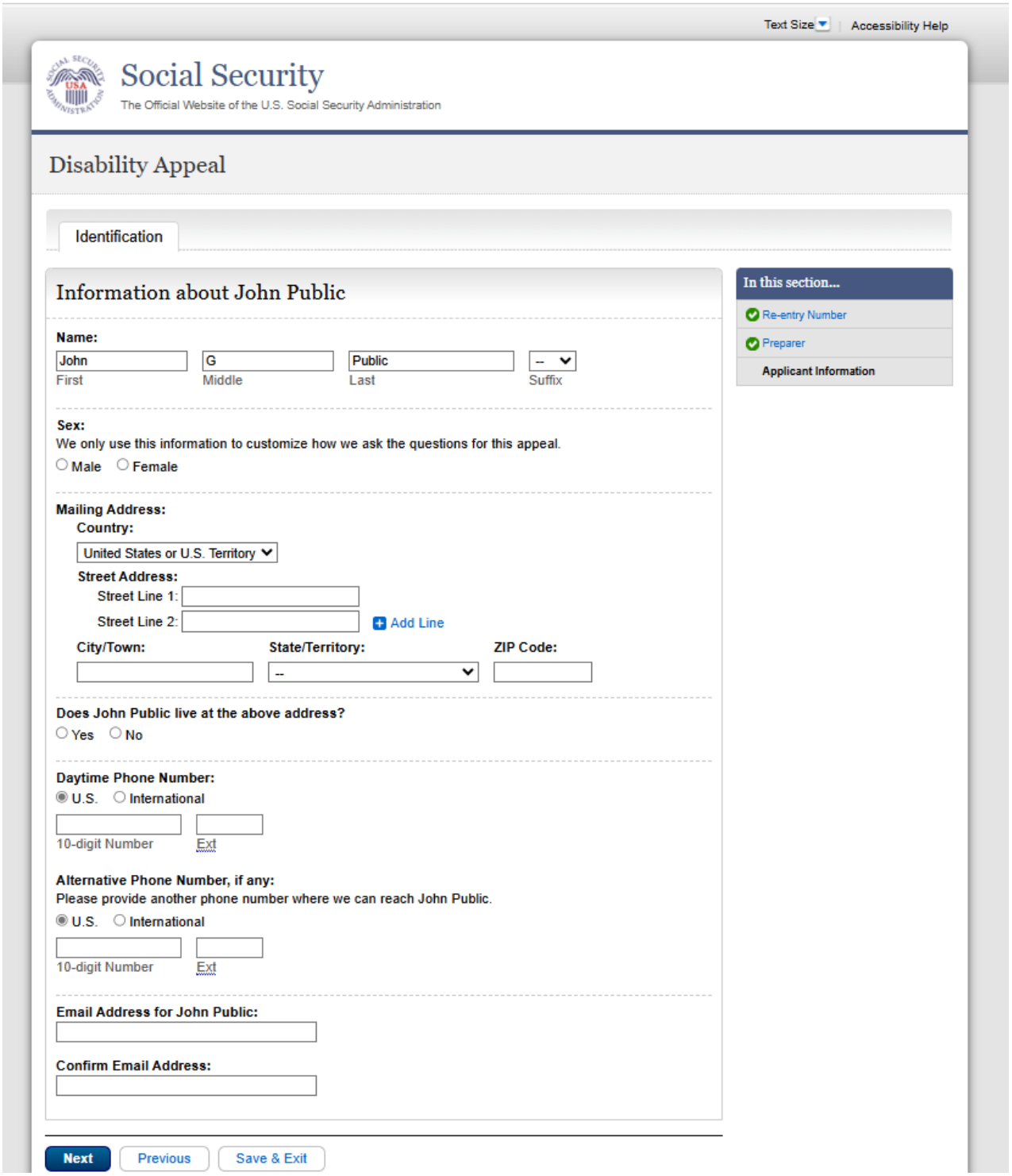


3rd Party: Form Completer: Preparer's Info (Frmc001)

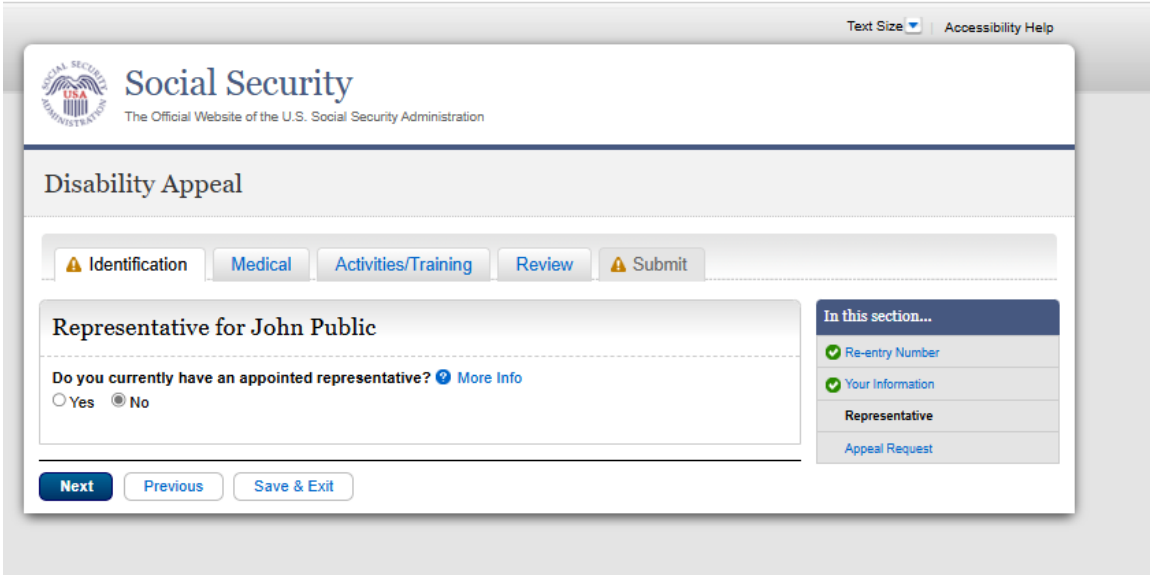
1st Party: Applicant Information (Appd001-1)

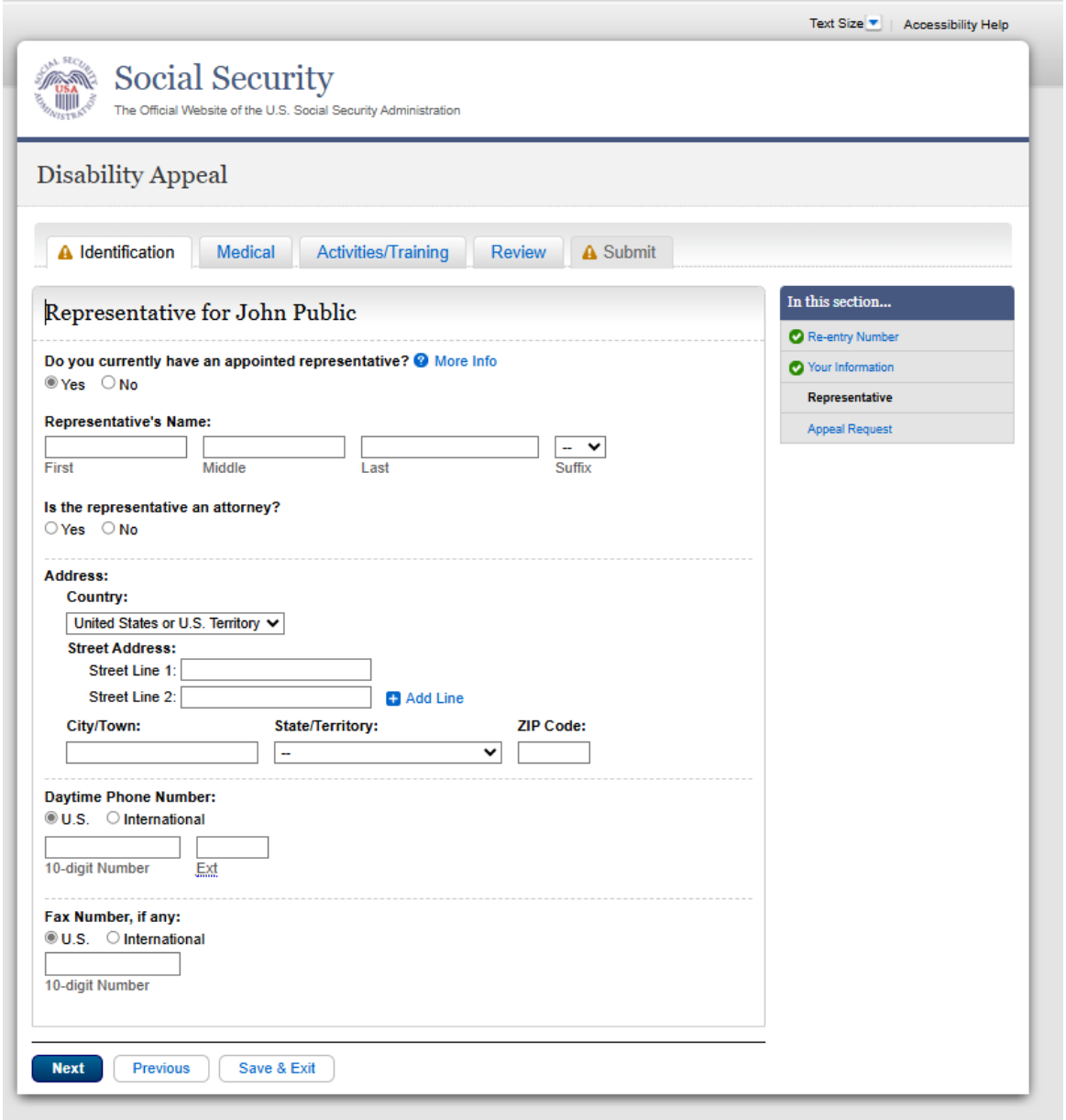


3rd Party: Applicant Information (Appd001-3)

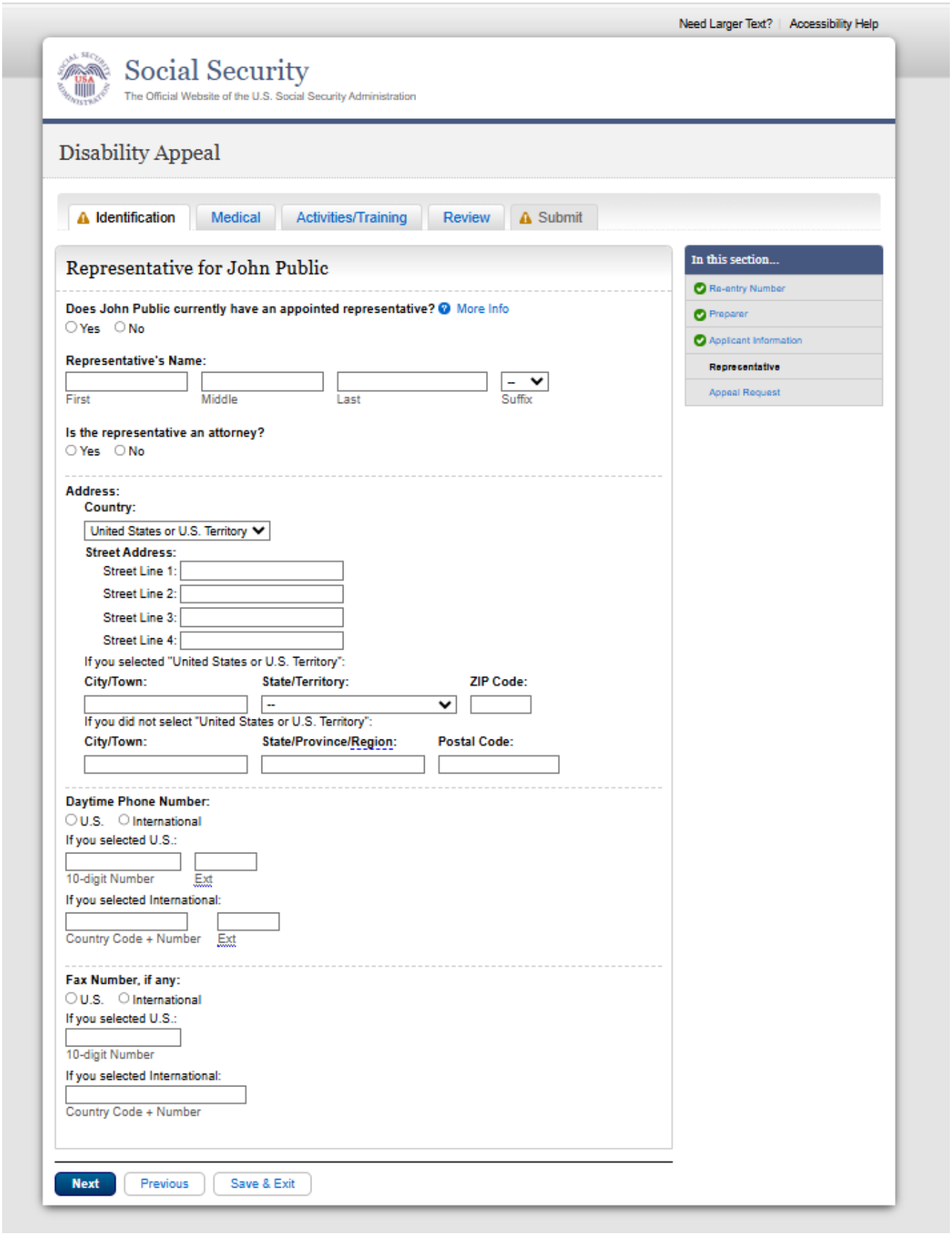


1st Party: Representative Info (Rpnp001-1)





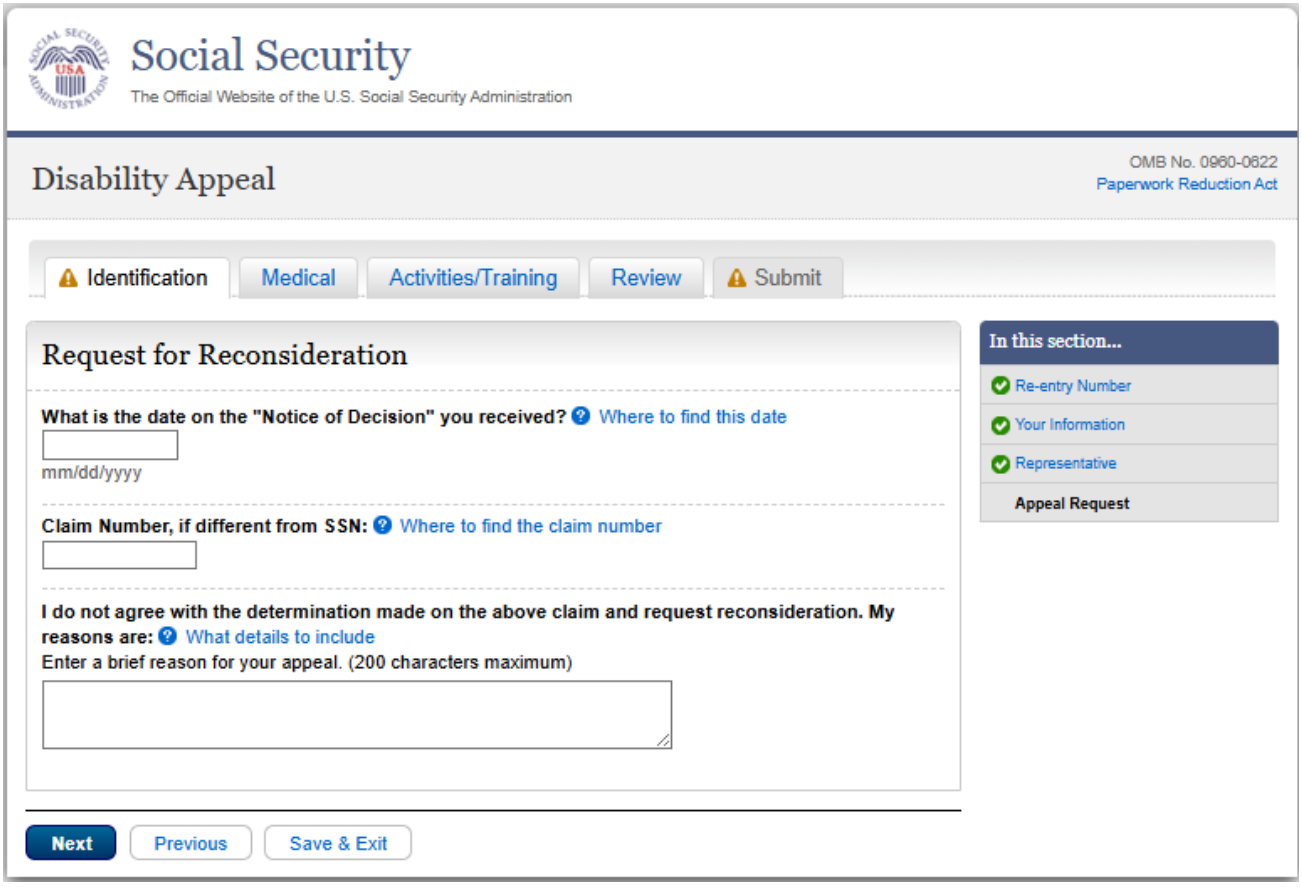
3rd Party: Representative Info (Rpnp001-3)



1st Party: Request for Hearing (Appl001hr-1)

3rd Party: Request for Hearing (Appl001hr-3)

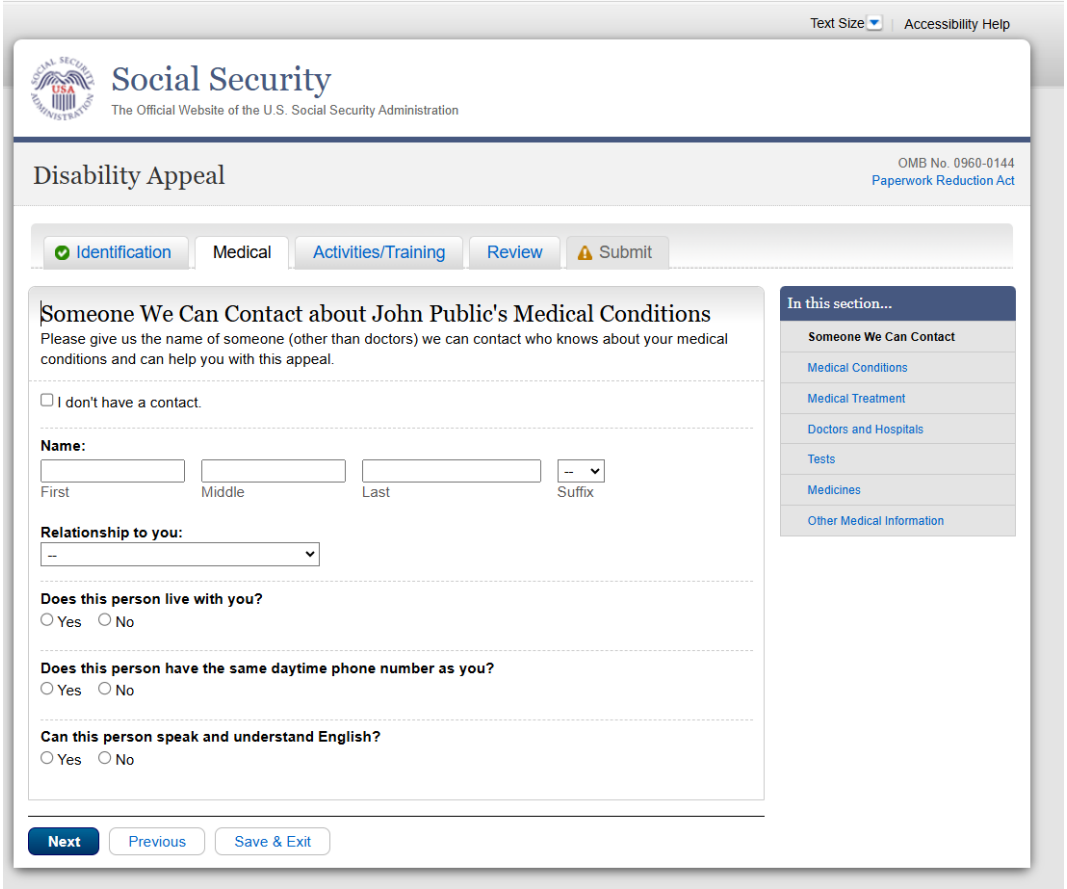
1st Party: Request for Reconsideration (Appl001rec-1)



3rd Party: Request for Reconsideration (Appl001rec-3)

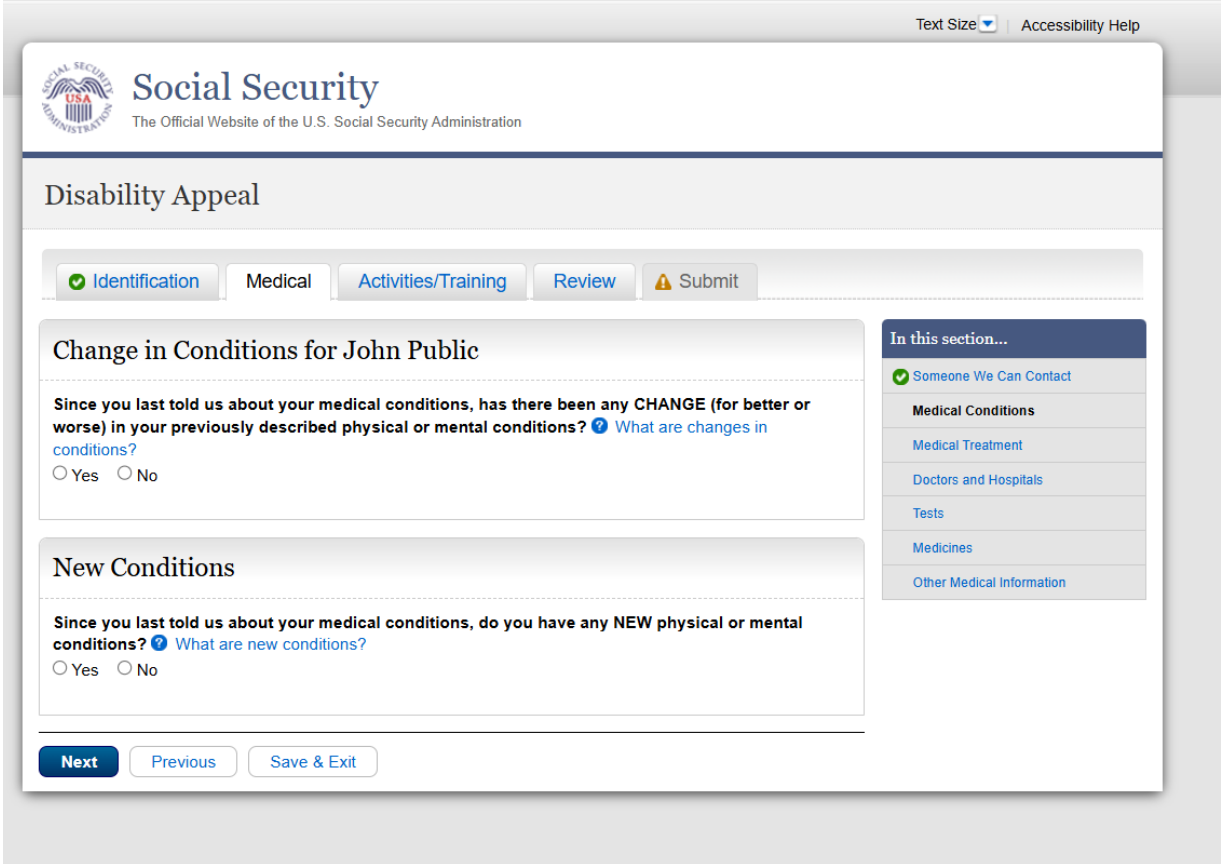
Section: Medical Pages

1st Party: Contact Information (Cnti001-1)

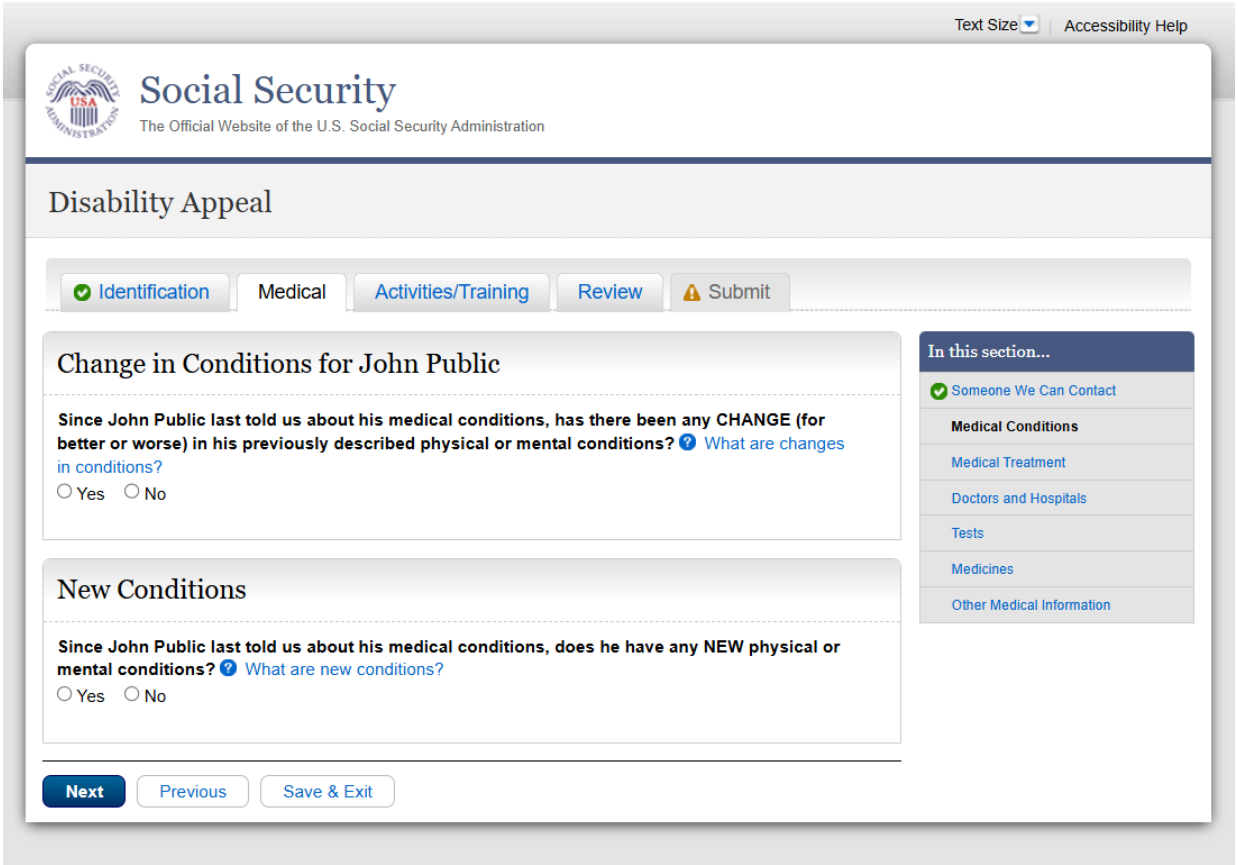


3rd Party: Contact Information (Cnti001-3)

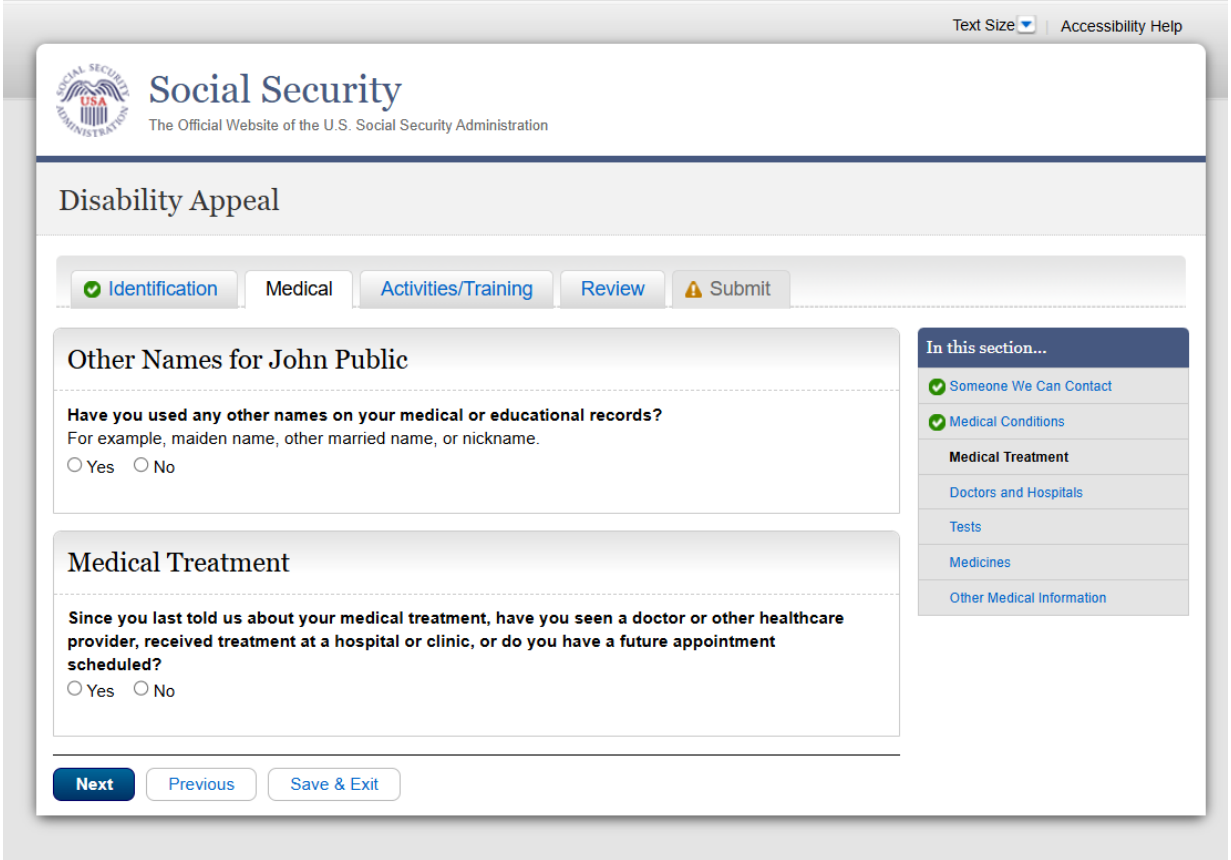
1st Party: Change in Medical Conditions (Cicd001-1)



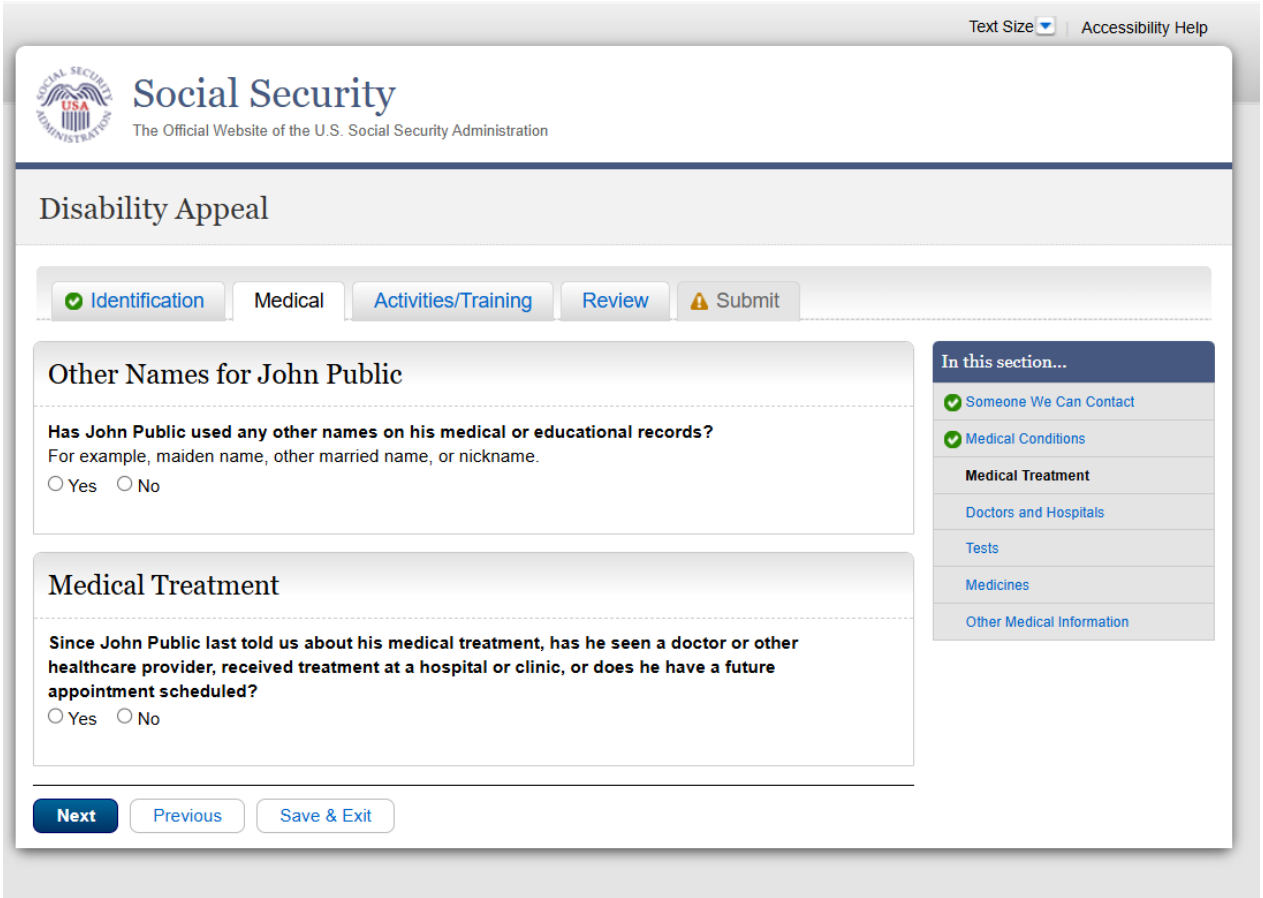
3rd Party: Change in Medical Conditions (Cicd001-3)



1st Party: Medical Treatment (Nmed001-1)



3rd Party: Medical Treatment (Nmed001-3)



1st Party: List of Doctors and Hospitals (Doho001-1)

3rd Party: List of Doctors and Hospitals (Doho001-3)

1st Party: Specific Doctor Detailed Information (Doct002-1)

Text Size | Accessibility Help

Social Security
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Disability Appeal

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

-- | | | --
Title | First | Last | Suffix

Name of Practice or Medical Group:

Phone Number:

(•) U.S. ( ) International

10-digit Number | Ext

Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: | **State/Territory:** | **ZIP Code:**

--

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Since you last told us about your last medical treatment, has there been any new or updated treatment? Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What new or updated treatment did you receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

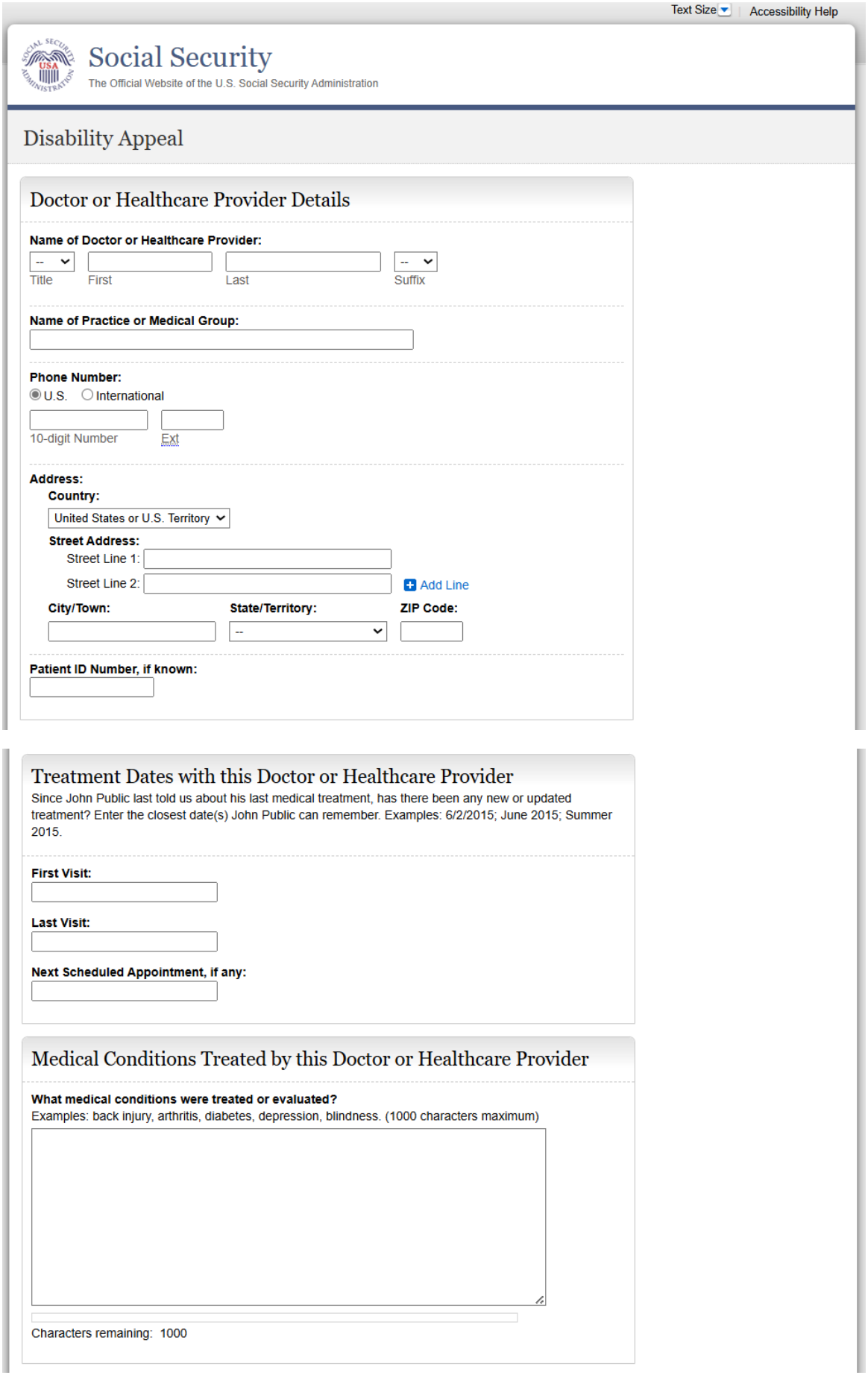
Please add **ALL prescription and non-prescription medicines** that you are currently taking that this doctor or healthcare provider recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save Cancel

3rd Party: Specific Doctor Detailed Information (Doct002-3)



Text Size | Accessibility Help

Social Security
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Disability Appeal

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:

-- | | | --
Title | First | Last | Suffix

Name of Practice or Medical Group:

Phone Number:

U.S. International

10-digit Number | Ext

Address:

Country:

United States or U.S. Territory

Street Address:

Street Line 1:

Street Line 2: Add Line

City/Town: **State/Territory:** **ZIP Code:**

--

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Since John Public last told us about his last medical treatment, has there been any new or updated treatment? Enter the closest date(s) John Public can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

What new or updated treatment did John Public receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered by this Doctor or Healthcare Provider

Please add any tests this doctor or healthcare provider ordered for John Public, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Doctor or Healthcare Provider

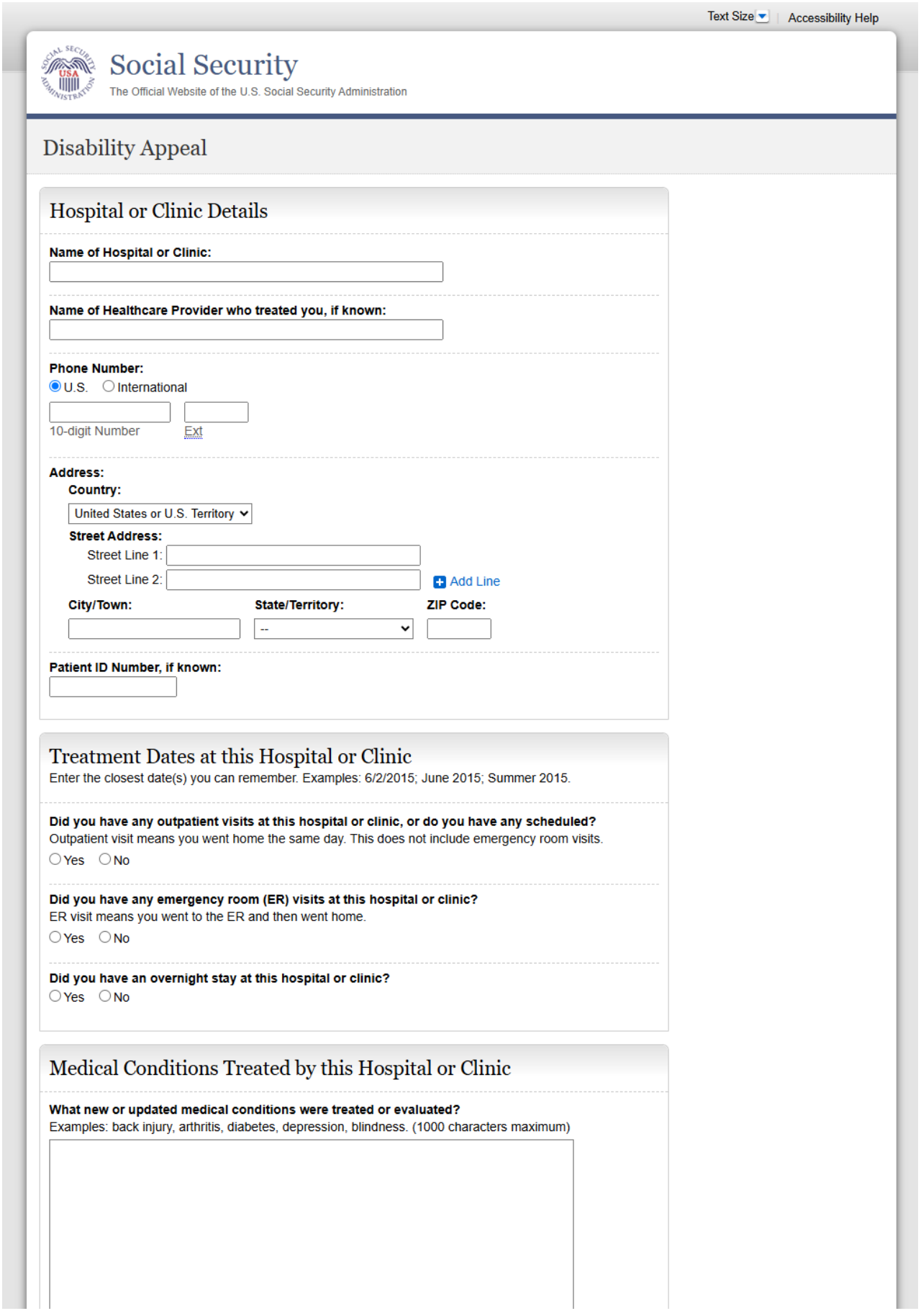
Please add **ALL prescription and non-prescription medicines** that John Public is currently taking that this doctor or healthcare provider recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save Cancel

1st Party: Specific Hospital Detailed Information (Hosp002-1)



Text Size | Accessibility Help

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Disability Appeal

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:
U.S. International
10-digit Number Ext

Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2: Add Line
City/Town: **State/Territory:** -- **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?
Outpatient visit means you went home the same day. This does not include emergency room visits.
Yes No

Did you have any emergency room (ER) visits at this hospital or clinic?
ER visit means you went to the ER and then went home.
Yes No

Did you have an overnight stay at this hospital or clinic?
Yes No

Medical Conditions Treated by this Hospital or Clinic

What new or updated medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What new or updated treatment did you receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for you, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

Please add **ALL prescription and non-prescription medicines** that you are currently taking that this hospital or clinic recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

Add Medicine

Save Cancel

3rd Party: Specific Hospital Detailed Information (Hosp002-3)

Text Size | Accessibility Help

Social Security
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Disability Appeal

Hospital or Clinic Details

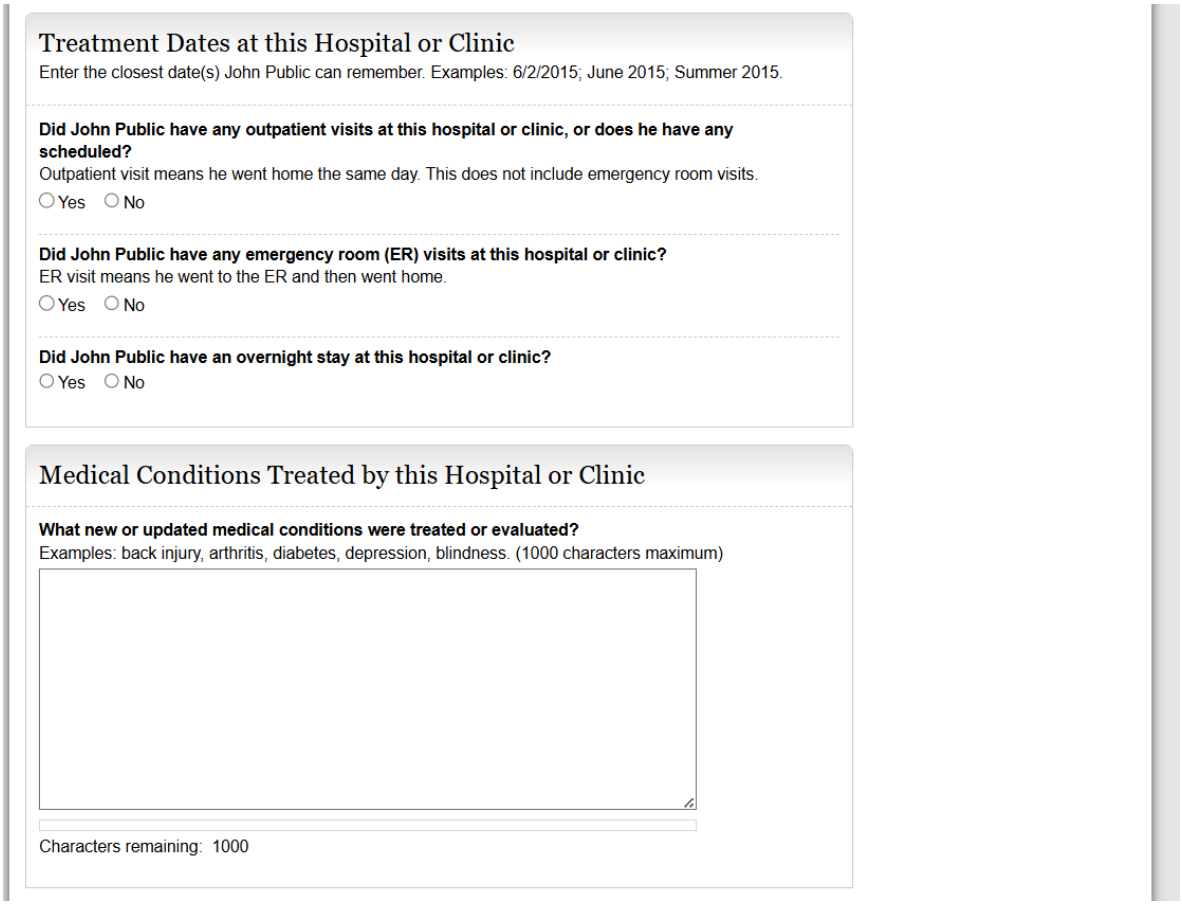
Name of Hospital or Clinic:

Name of Healthcare Provider who treated John Public, if known:

Phone Number:
U.S. International
10-digit Number Ext

Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2: Add Line
City/Town: **State/Territory:** **ZIP Code:**
--

Patient ID Number, if known:



Treatment Dates at this Hospital or Clinic

Enter the closest date(s) John Public can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did John Public have any outpatient visits at this hospital or clinic, or does he have any scheduled?
Outpatient visit means he went home the same day. This does not include emergency room visits.
Yes No

Did John Public have any emergency room (ER) visits at this hospital or clinic?
ER visit means he went to the ER and then went home.
Yes No

Did John Public have an overnight stay at this hospital or clinic?
Yes No

Medical Conditions Treated by this Hospital or Clinic

What new or updated medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Hospital or Clinic

What new or updated treatment did John Public receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Tests Ordered at this Hospital or Clinic

Please add any tests this hospital or clinic ordered for John Public, including those scheduled in the future. You will have another opportunity to provide this information.

Status	Name of Test	Actions
Click "Add Test" to add a test.		

Add Test

Medicines Recommended or Prescribed by this Hospital or Clinic

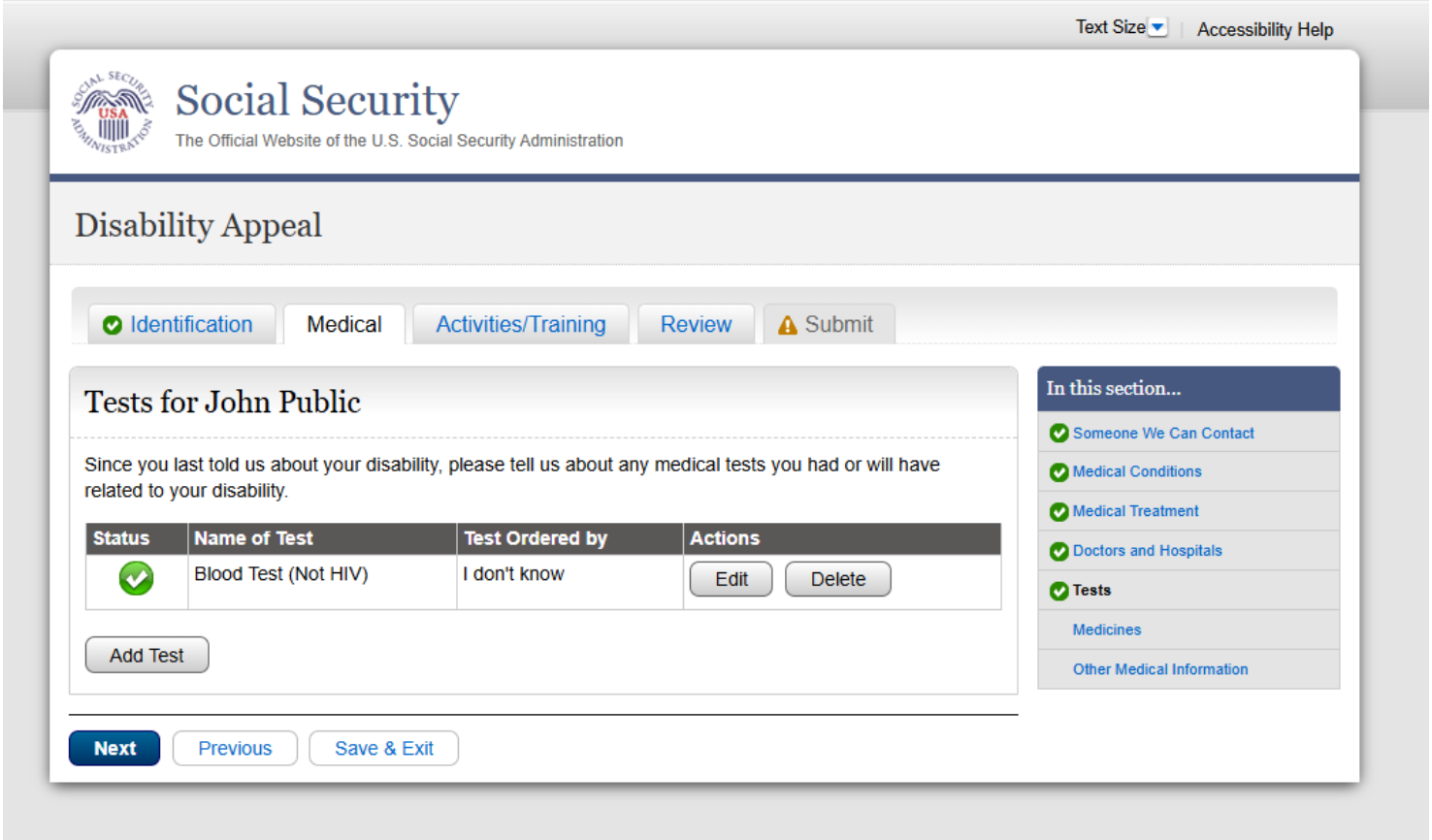
Please add **ALL prescription and non-prescription medicines** that John Public is currently taking that this hospital or clinic recommended or prescribed.

Status	Name of Medicine	Reason	Actions
Click "Add Medicine" to add a medicine.			

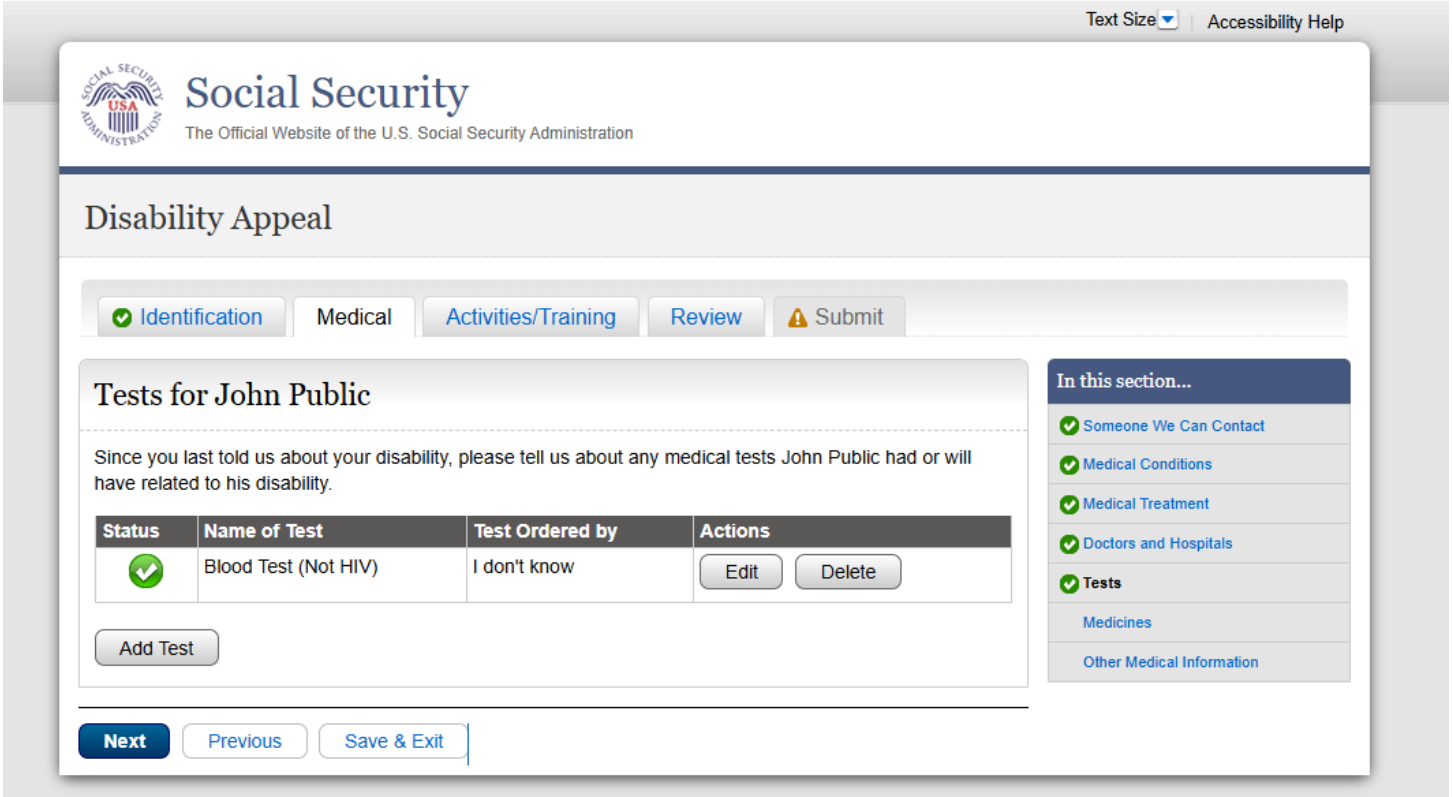
Add Medicine

Save Cancel

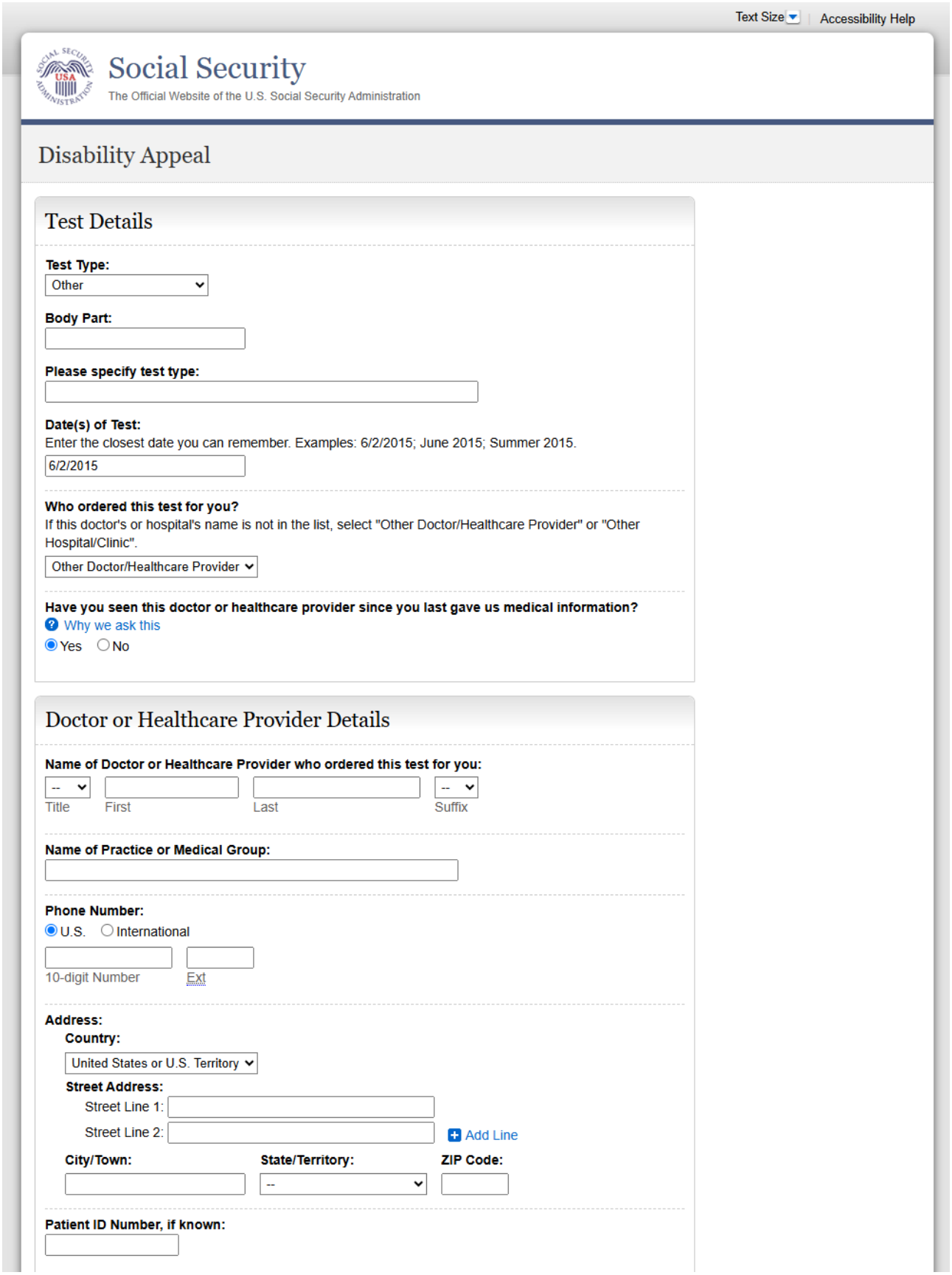
1st Party: List of Tests (Test001-1)



3rd Party: List of Tests (Test001-3)



1st Party: Specific Test Detailed Information (Test002-1)



Treatment Dates with this Doctor or Healthcare Provider

Since you last told us about your last medical treatment, has there been any new or updated treatment? Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?

Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

Treatment from this Doctor or Healthcare Provider

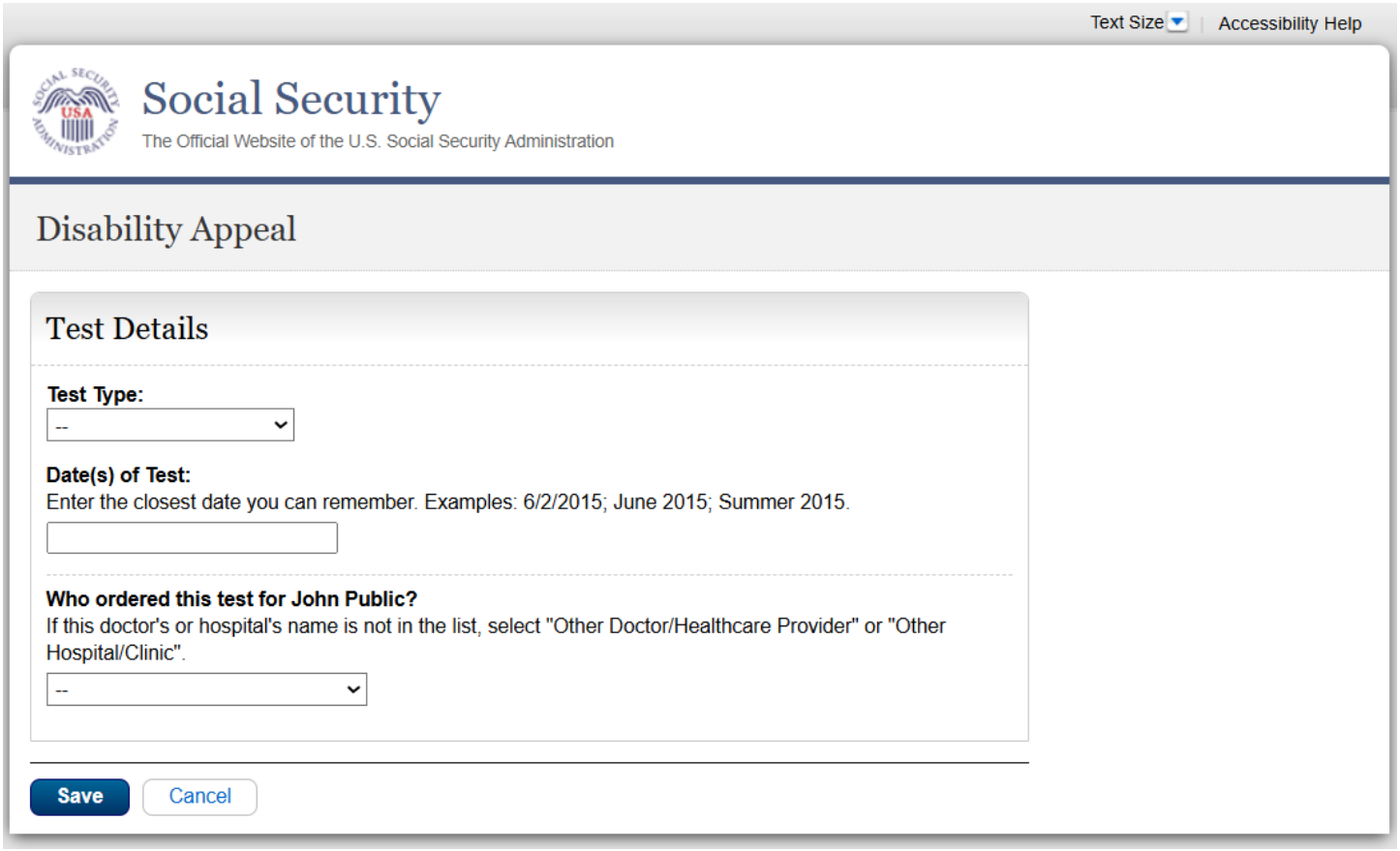
What new or updated treatment did you receive for the above conditions?

You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Save Cancel

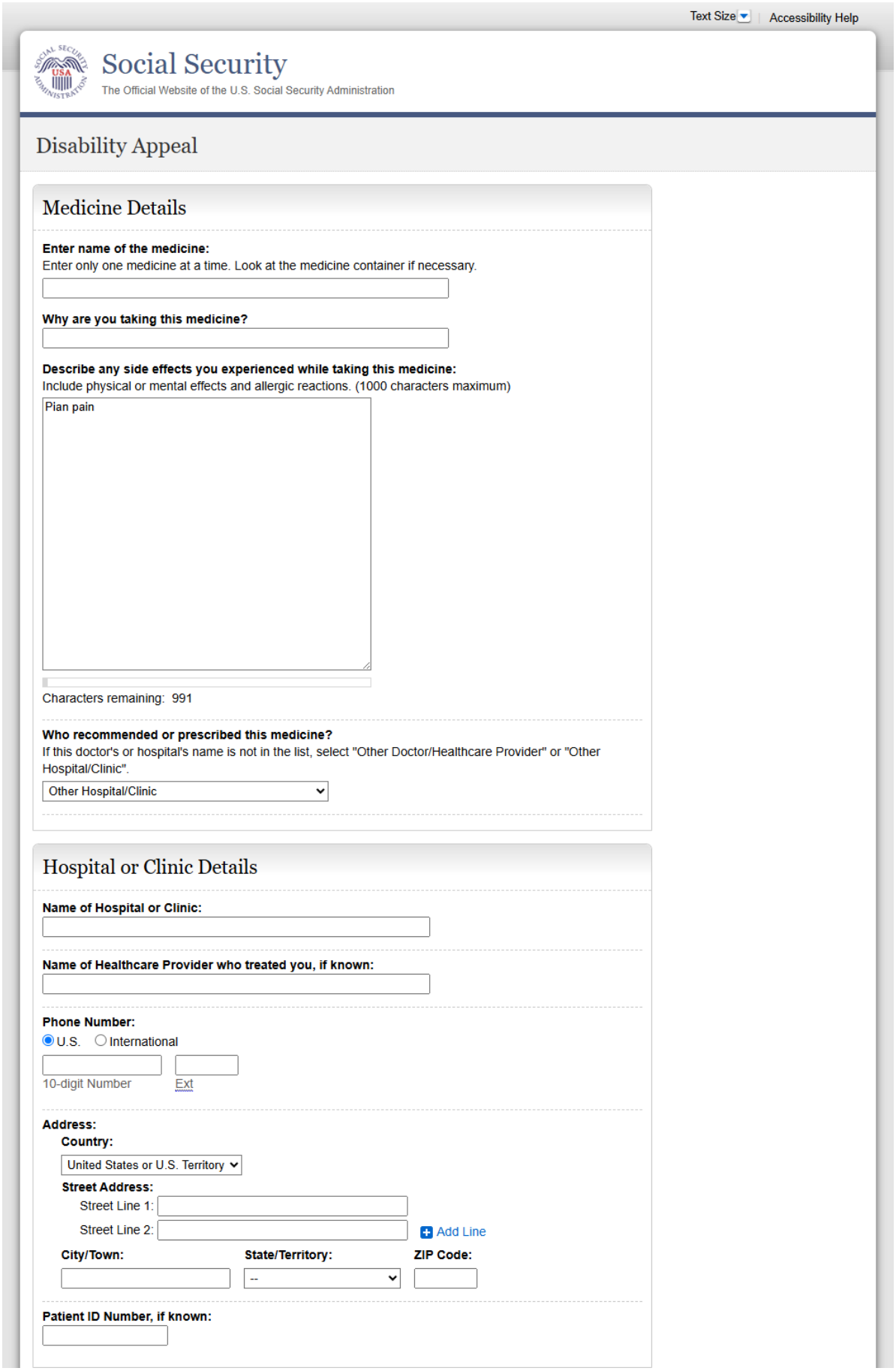
3rd Party: Specific Test Detailed Information (Test002-3)



1st Party: List of Medicines (Medi001-1)

3rd Party: List of Medicines (Medi001-3)

1st Party: Specific Medicine Detailed Information (Medi002-1)



Text Size | Accessibility Help

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Disability Appeal

Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Pian pain

Characters remaining: 991

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Other Hospital/Clinic

Hospital or Clinic Details

Name of Hospital or Clinic:

Name of Healthcare Provider who treated you, if known:

Phone Number:
U.S. International
10-digit Number Ext

Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2: Add Line
City/Town: **State/Territory:** -- **ZIP Code:**

Patient ID Number, if known:

Treatment Dates at this Hospital or Clinic

Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Did you have any outpatient visits at this hospital or clinic, or do you have any scheduled?
Outpatient visit means you went home the same day. This does not include emergency room visits.

(•) Yes ( ) No

First outpatient visit:

Last outpatient visit:

Next scheduled outpatient visit (if any):

Did you have any emergency room (ER) visits at this hospital or clinic?
ER visit means you went to the ER and then went home.

(•) Yes ( ) No

Please give the dates of your most recent emergency room visits.

Emergency Room Visit 1:

Emergency Room Visit 2:

Emergency Room Visit 3:

Did you have an overnight stay at this hospital or clinic?

(•) Yes ( ) No

Give us the dates of your three most recent stays.

Visit 1:

Date In | Date Out

Visit 2:

Date In | Date Out

Visit 3:

Date In | Date Out

Medical Conditions Treated by this Hospital or Clinic

What new or updated medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

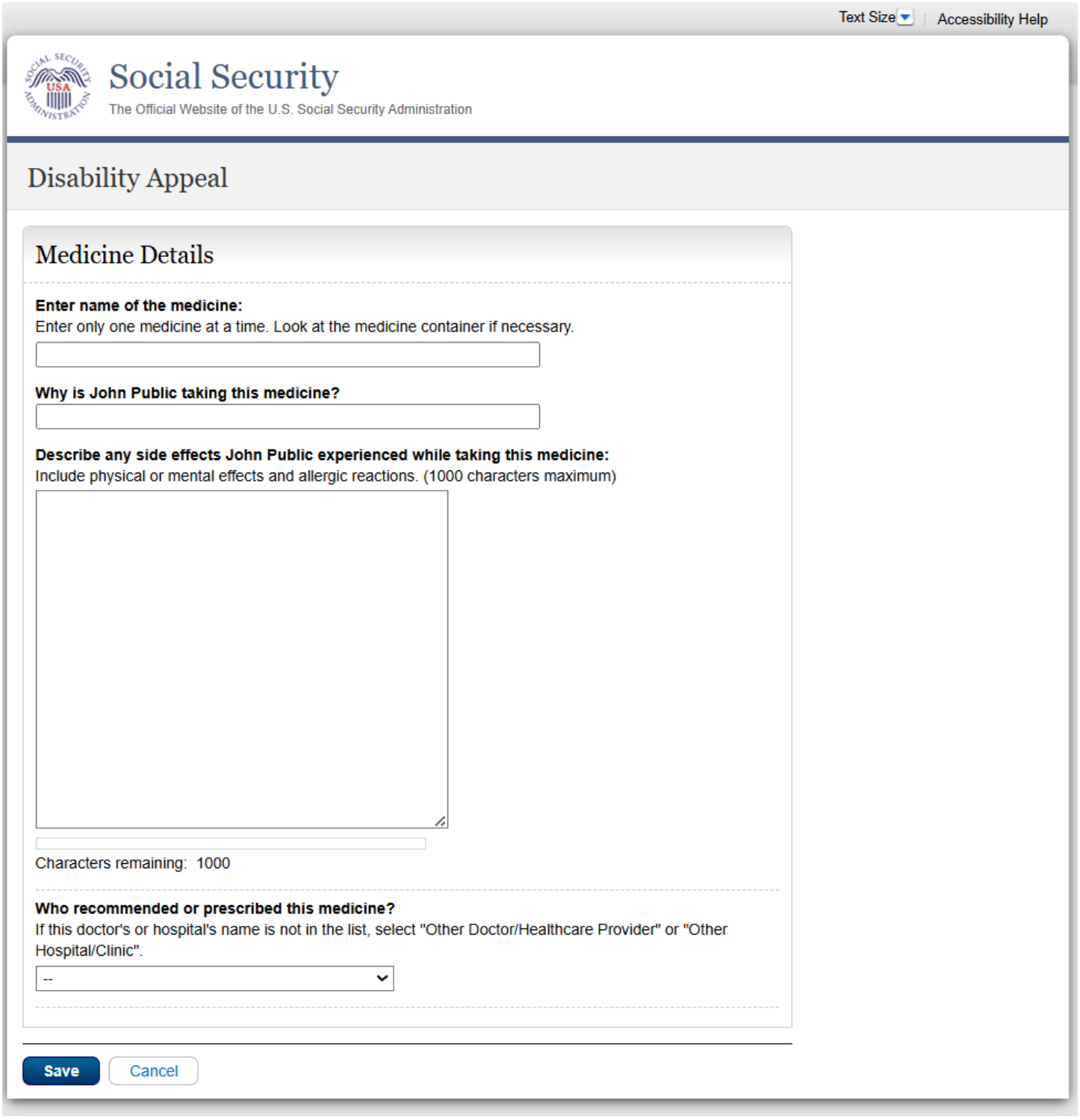
Treatment from this Hospital or Clinic

What new or updated treatment did you receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

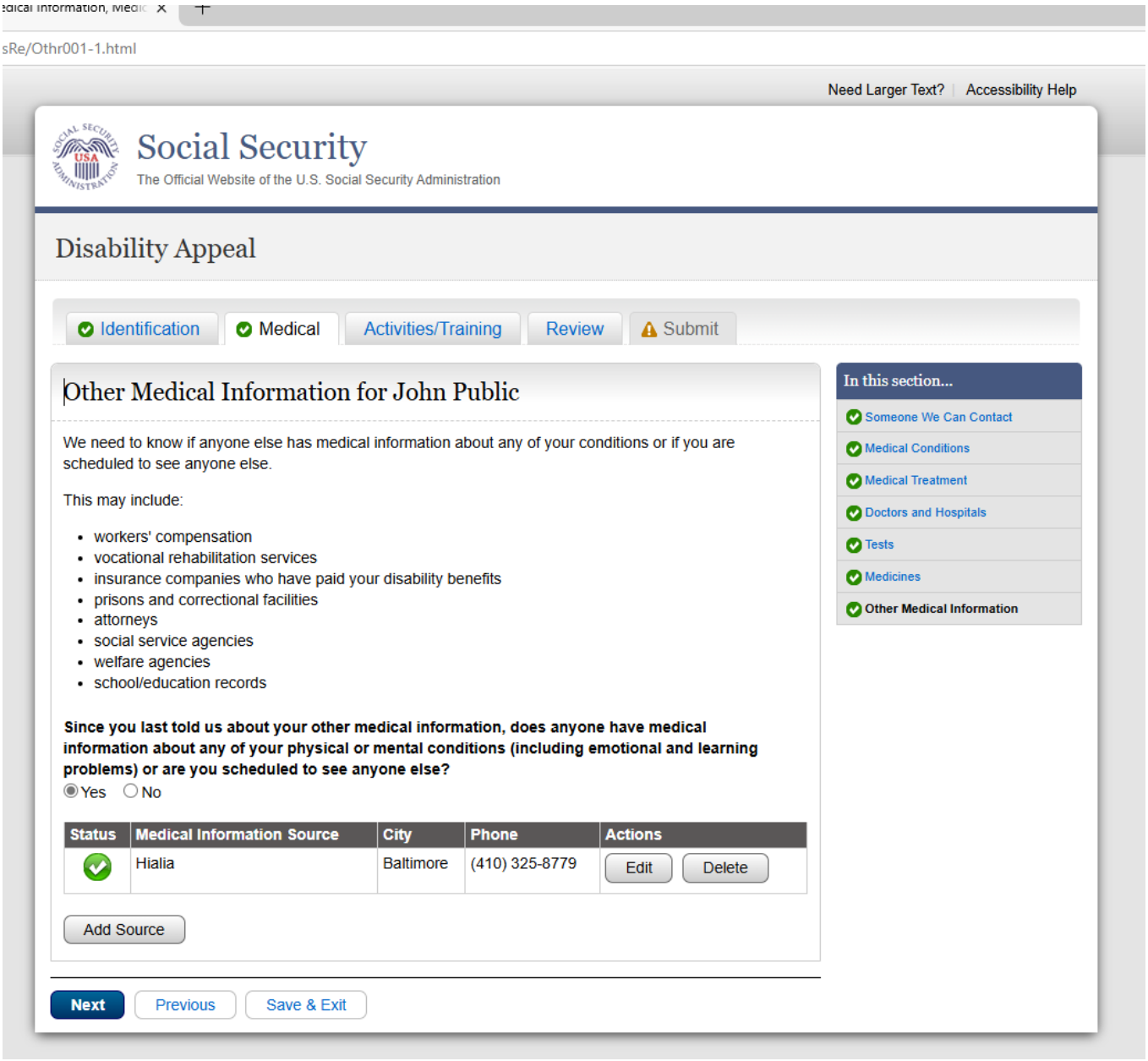
Characters remaining: 1000

Save Cancel

3rd Party: Specific Medicine Detailed Information (Medi002-3)

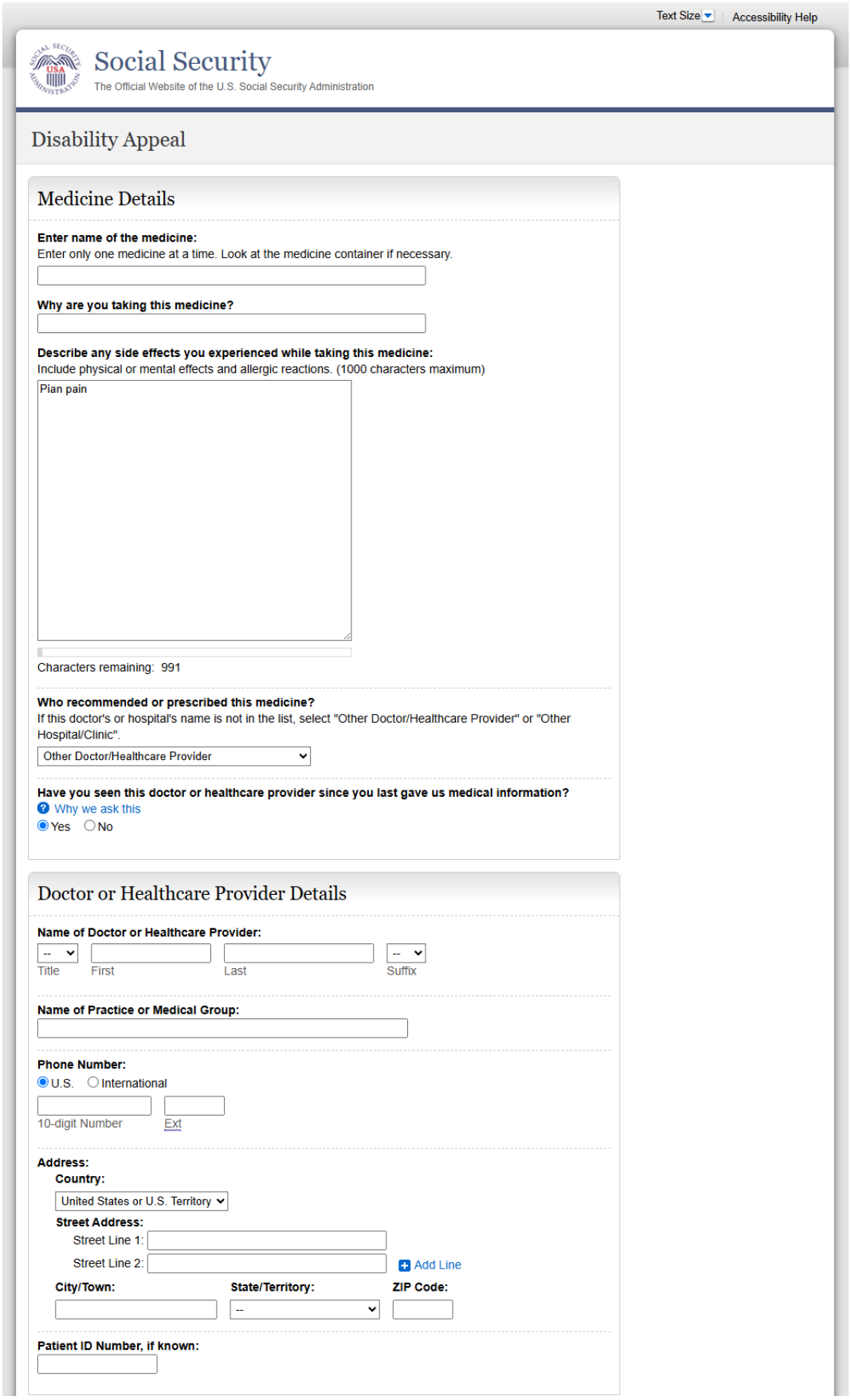


1st Party: Other Medical Records (Othr001-1)



3rd Party: Other Medical Records (Othr001-3)

1st Party: Details of Other Medical Information (Othr002-1)



Text Size | Accessibility Help

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Disability Appeal

Medicine Details

Enter name of the medicine:
Enter only one medicine at a time. Look at the medicine container if necessary.

Why are you taking this medicine?

Describe any side effects you experienced while taking this medicine:
Include physical or mental effects and allergic reactions. (1000 characters maximum)

Pian pain

Characters remaining: 991

Who recommended or prescribed this medicine?
If this doctor's or hospital's name is not in the list, select "Other Doctor/Healthcare Provider" or "Other Hospital/Clinic".

Other Doctor/Healthcare Provider

Have you seen this doctor or healthcare provider since you last gave us medical information?
Why we ask this
Yes No

Doctor or Healthcare Provider Details

Name of Doctor or Healthcare Provider:
Title First Last Suffix

Name of Practice or Medical Group:

Phone Number:
U.S. International
10-digit Number Ext

Address:
Country:
United States or U.S. Territory
Street Address:
Street Line 1:
Street Line 2: Add Line
City/Town: **State/Territory:** **ZIP Code:**

Patient ID Number, if known:

Treatment Dates with this Doctor or Healthcare Provider

Since you last told us about your last medical treatment, has there been any new or updated treatment? Enter the closest date(s) you can remember. Examples: 6/2/2015; June 2015; Summer 2015.

First Visit:

Last Visit:

Next Scheduled Appointment, if any:

Medical Conditions Treated by this Doctor or Healthcare Provider

What medical conditions were treated or evaluated?
Examples: back injury, arthritis, diabetes, depression, blindness. (1000 characters maximum)

Characters remaining: 1000

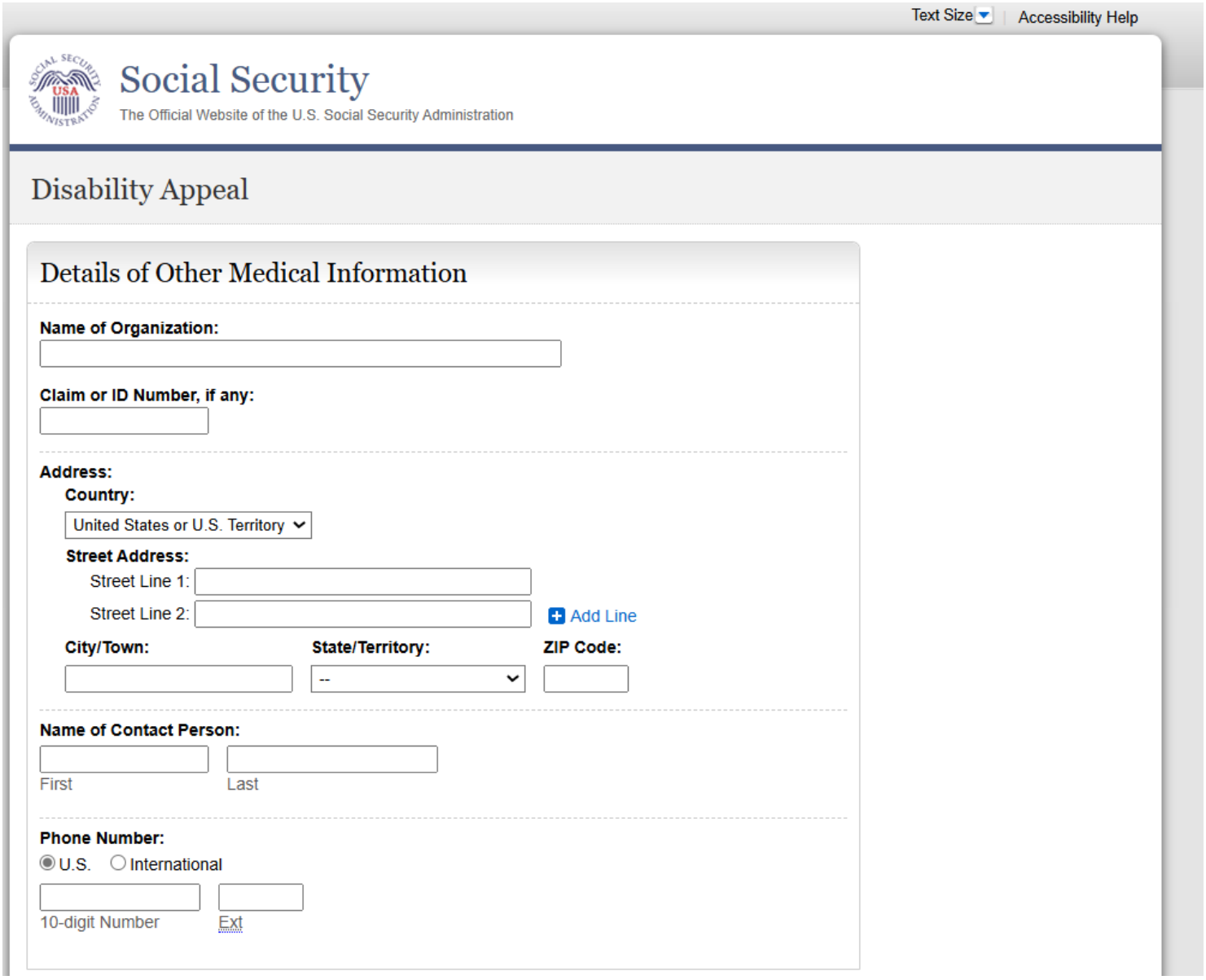
Treatment from this Doctor or Healthcare Provider

What new or updated treatment did you receive for the above conditions?
You DO NOT need to include medicines and tests in this answer. Examples of treatment: examinations, regular evaluations, check ups, physical therapy, chemotherapy, counseling. (1000 characters maximum)

Characters remaining: 1000

Save Cancel

3rd Party: Details of Other Medical Information (Othr002-3)



Contacts with this Organization

Examples: visits to workers' compensation attorney, doctor/clinic in prison, or school counselor. Enter the closest date(s) John Public can remember. Examples: 6/2/2015; June 2015; Summer 2015.

Date of First Contact:

Date of Last Contact:

Date of Next Contact, if any:

Reasons for Contact:
(1000 characters maximum)

Characters remaining: 1000

If you need more space, continue in Remarks.

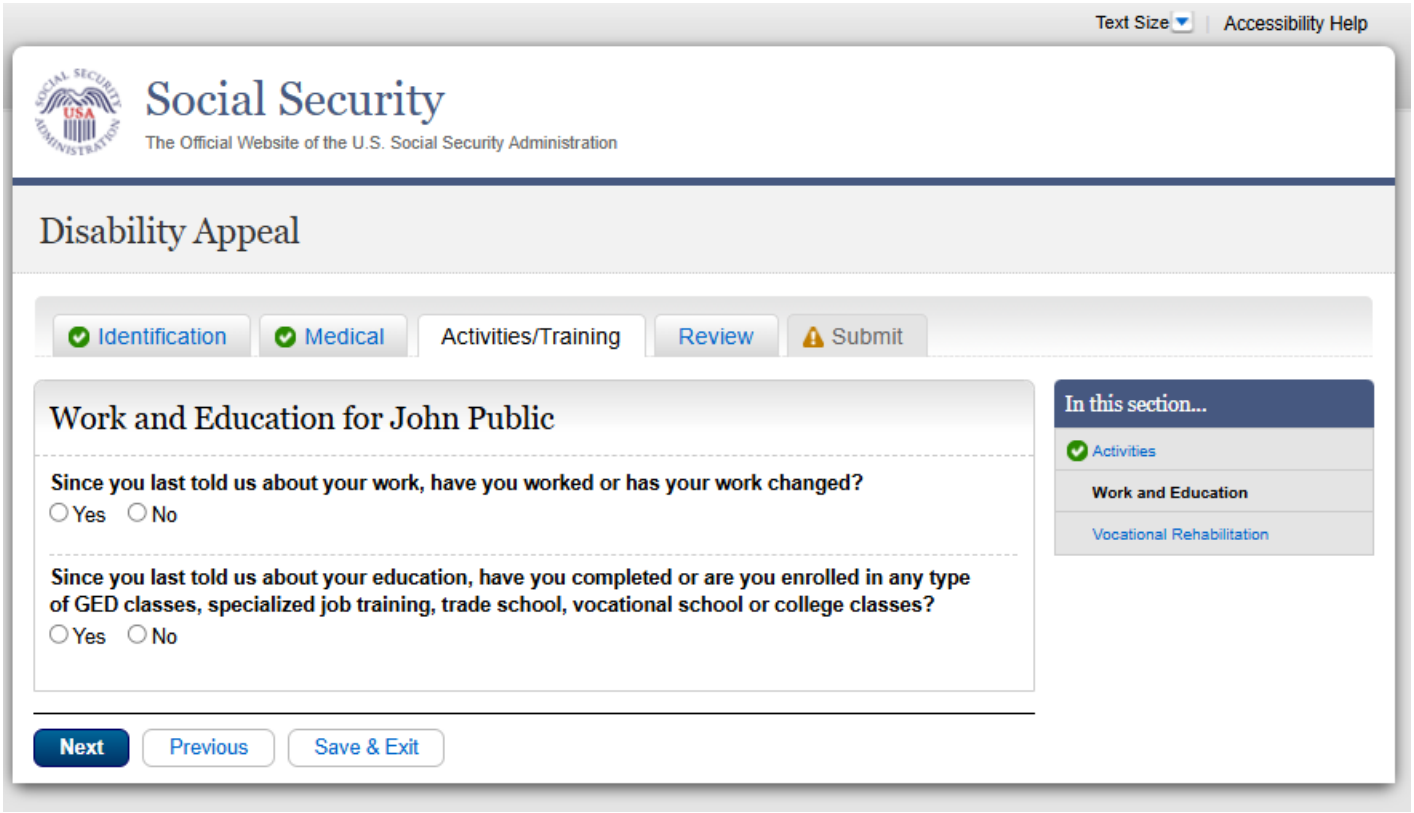
Save Cancel

Section: Activities and Training Pages

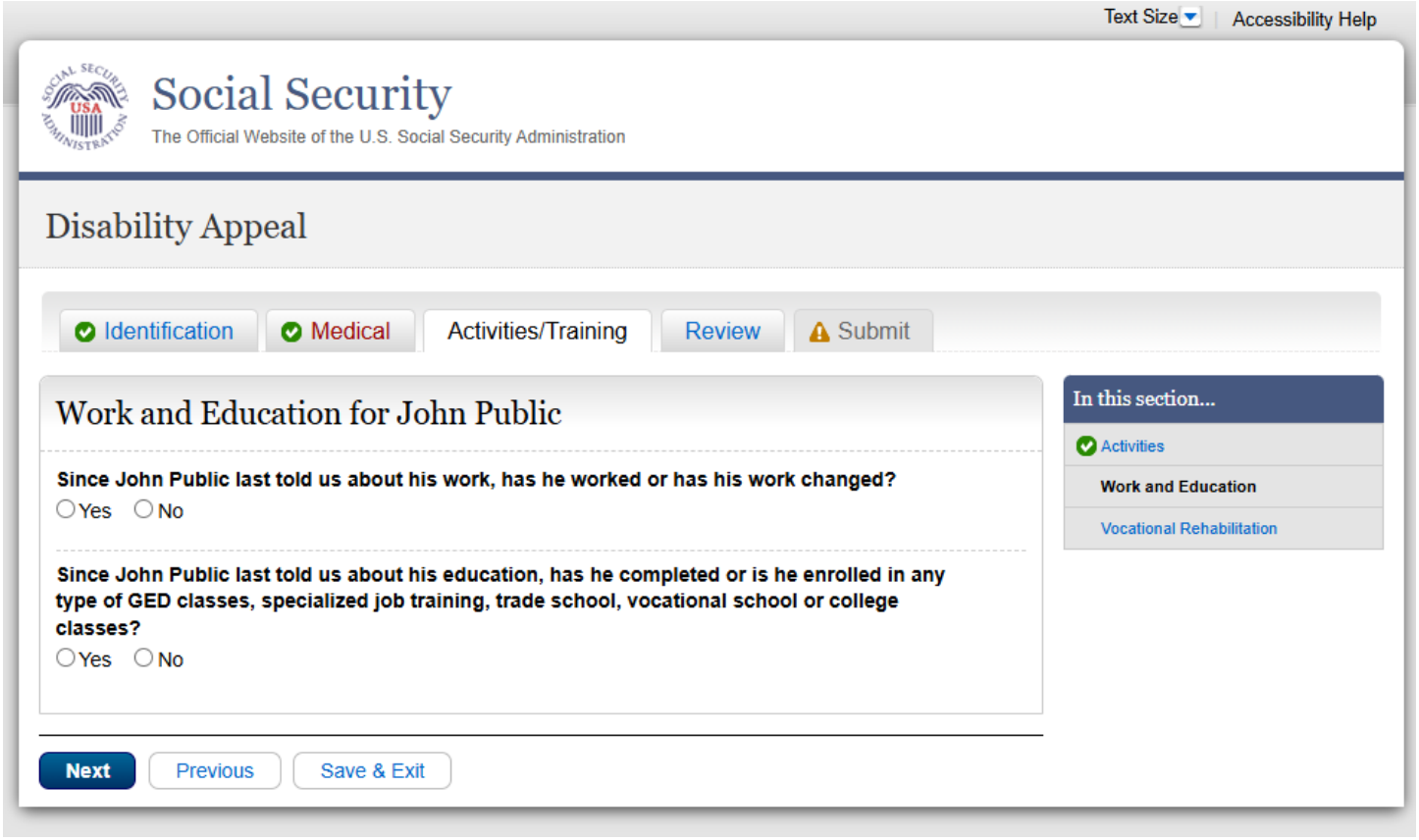
1st Party: Activities (Actv001-1)

3rd Party: Activities (Actv001-3)

1st Party: Work, Education & Training (Wetr001-1)

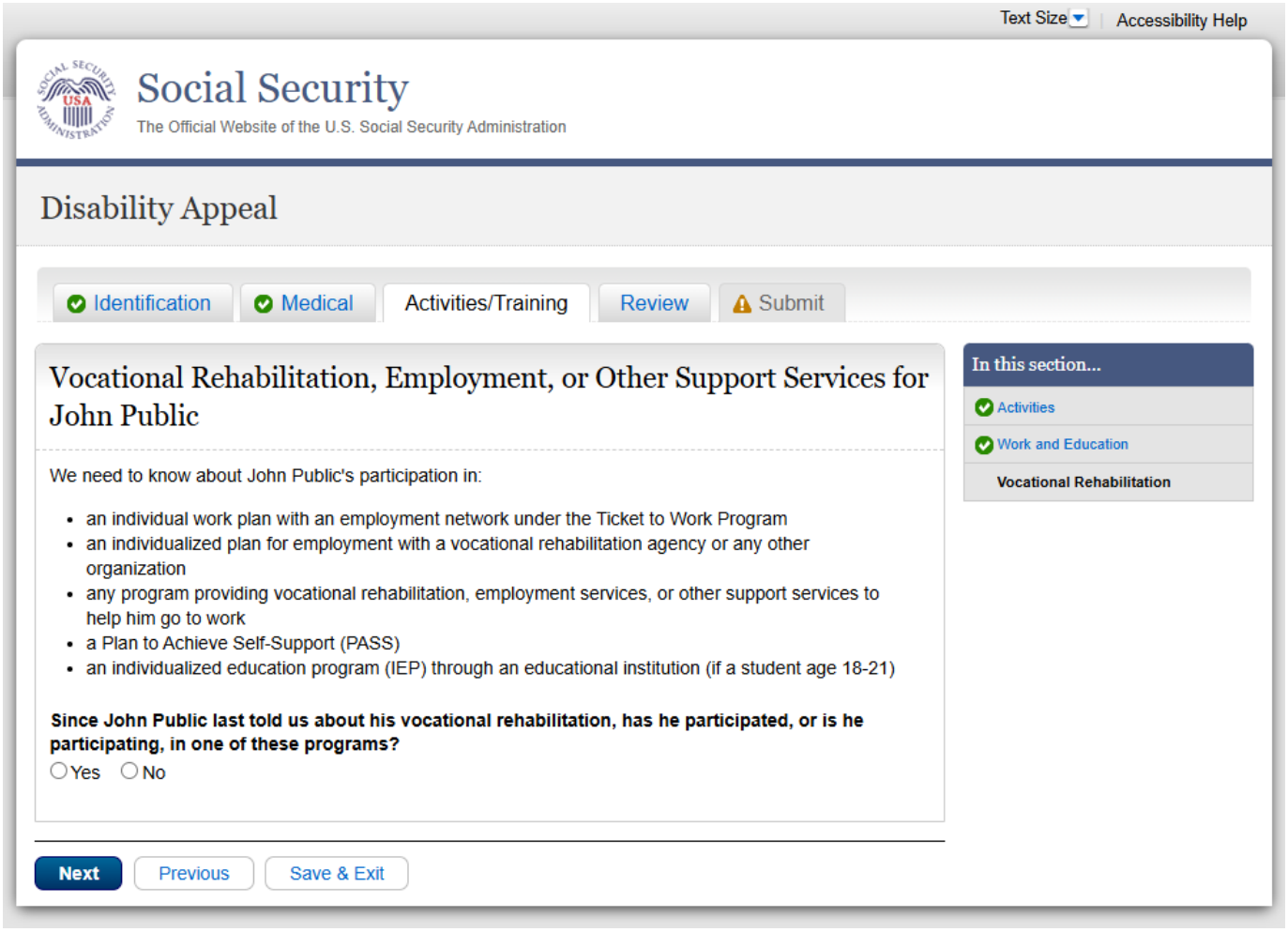


3rd Party: Work, Education & Training (Wetr001-3)



1st Party: Vocational Rehabilitation (Voct001-1)

3rd Party: Vocational Rehabilitation (Voct001-3)

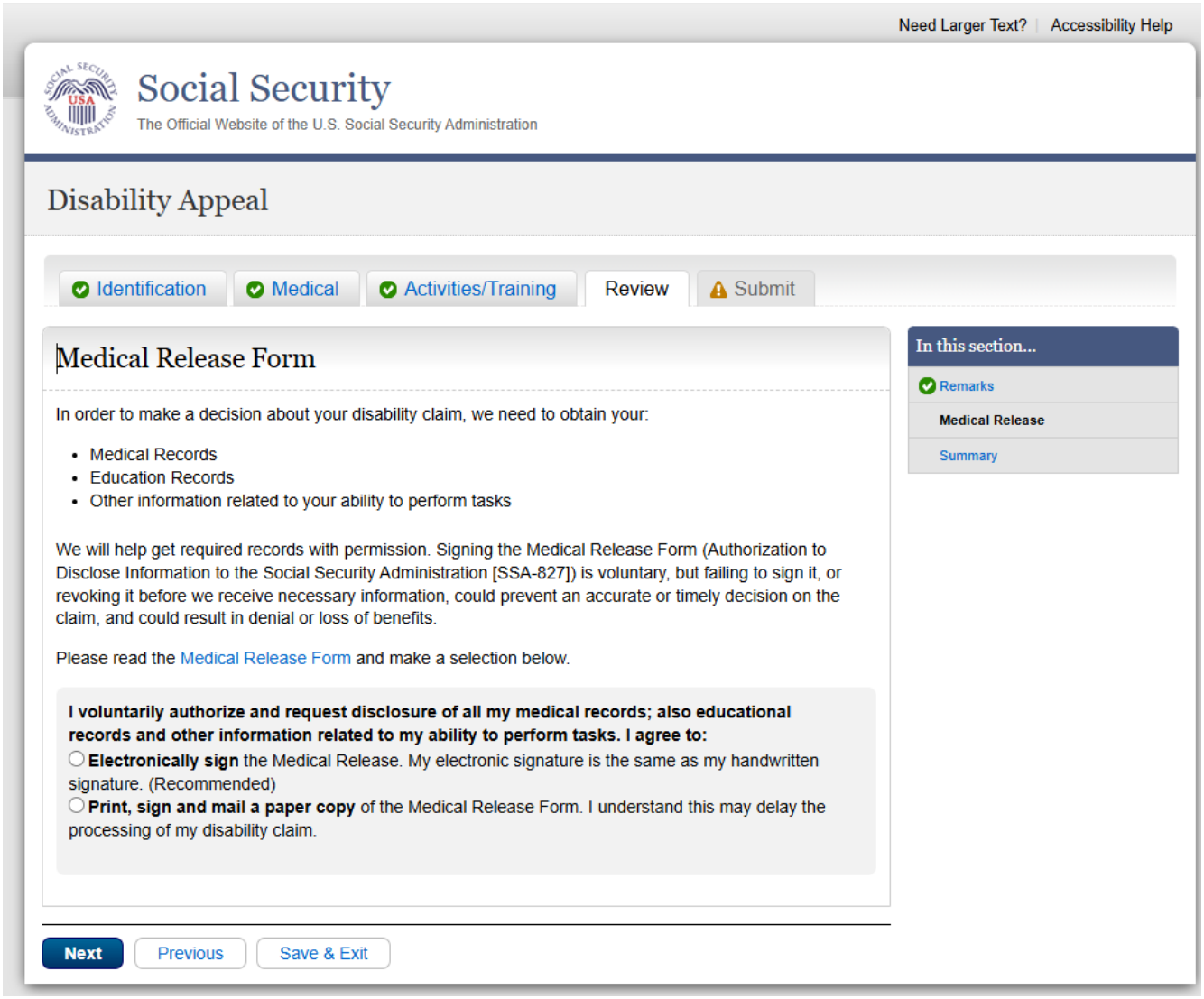


Section: Review and Submit Pages

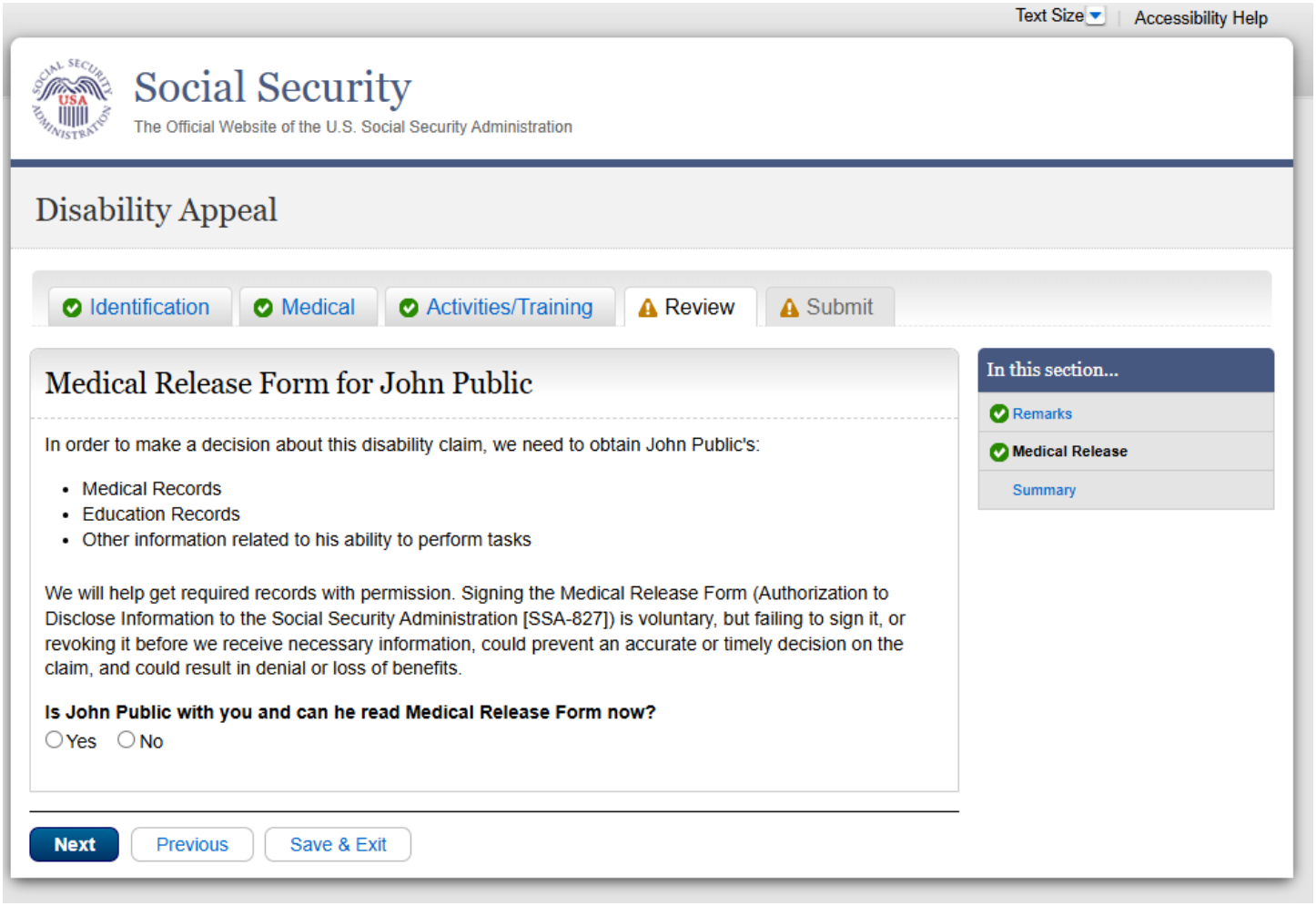
1st Party: Remarks (Rmks001-1)

3rd Party: Activities (Actv001-3)

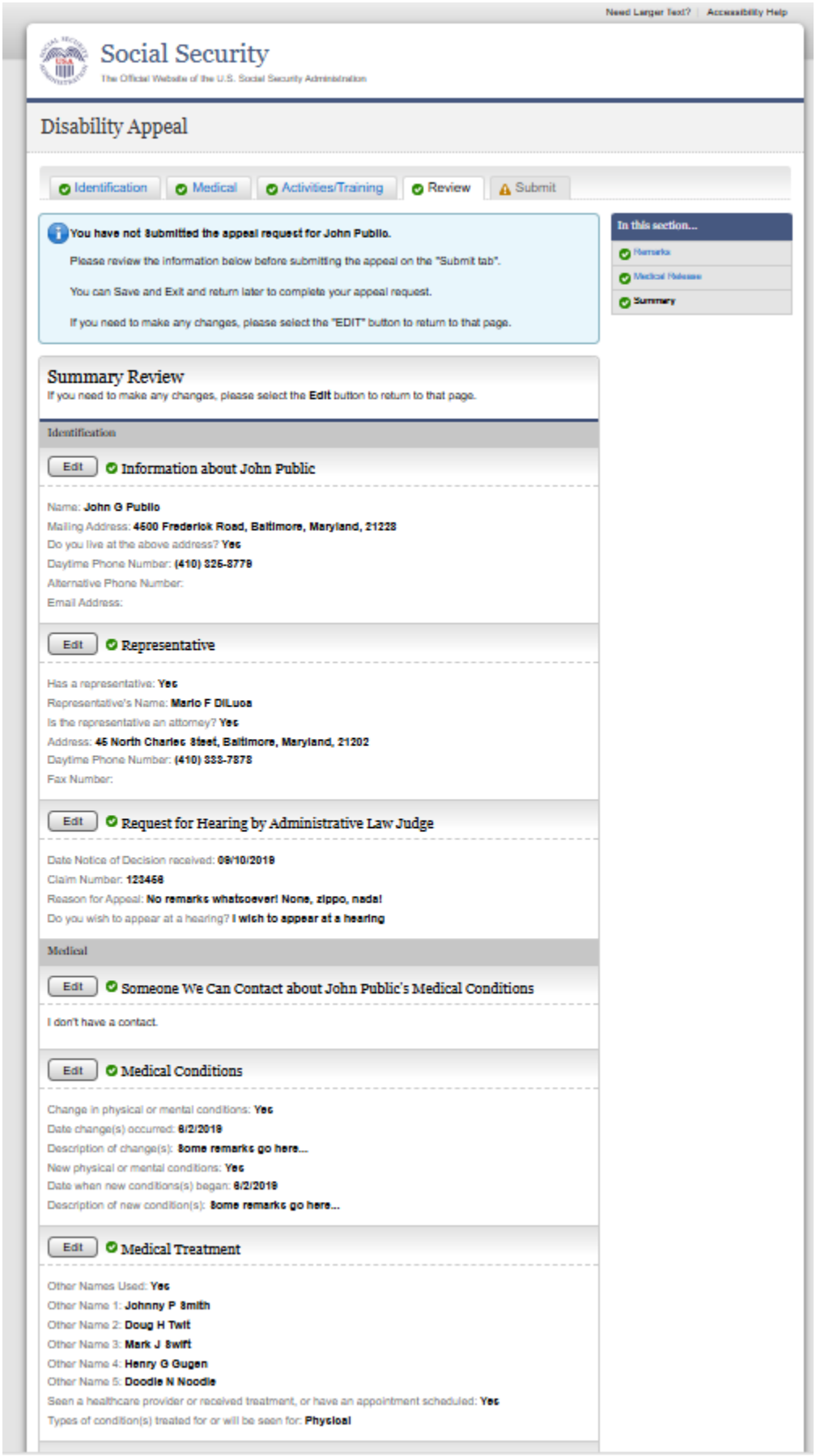
1st Party: Medical Release Form (Mdrf001-1)



3rd Party: Medical Release Form (Mdrf001-3)



1st Party: Summary (Revw001-1)



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Disability Appeal

Identification | Medical | Activities/Training | Review | Submit

You have not submitted the appeal request for John Public.

Please review the information below before submitting the appeal on the "Submit tab".

You can Save and Exit and return later to complete your appeal request.

If you need to make any changes, please select the "EDIT" button to return to that page.

In this section...
- Remarks
- Medical Release
- Summary

Summary Review

If you need to make any changes, please select the **Edit** button to return to that page.

Identification

Edit — Information about John Public

Name: **John G Public**
Mailing Address: **4500 Frederick Road, Baltimore, Maryland, 21228**
Do you live at the above address? **Yes**
Daytime Phone Number: **(410) 325-8778**
Alternative Phone Number:
Email Address:

Edit — Representative

Has a representative: **Yes**
Representative's Name: **Mario F DiLuca**
Is the representative an attorney? **Yes**
Address: **45 North Charles Steet, Baltimore, Maryland, 21202**
Daytime Phone Number: **(410) 333-7878**
Fax Number:

Edit — Request for Hearing by Administrative Law Judge

Date Notice of Decision received: **09/10/2018**
Claim Number: **123456**
Reason for Appeal: **No remarks whatsoever! None, zippo, nada!**
Do you wish to appear at a hearing? **I wish to appear at a hearing**

Medical

Edit — Someone We Can Contact about John Public's Medical Conditions

I don't have a contact.

Edit — Medical Conditions

Change in physical or mental conditions: **Yes**
Date change(s) occurred: **8/2/2018**
Description of change(s): **Some remarks go here...**
New physical or mental conditions: **Yes**
Date when new conditions(s) began: **8/2/2018**
Description of new condition(s): **Some remarks go here...**

Edit — Medical Treatment

Other Names Used: **Yes**
Other Name 1: **Johnny P Smith**
Other Name 2: **Doug H Twit**
Other Name 3: **Mark J Swift**
Other Name 4: **Henry G Gugen**
Other Name 5: **Doodle N Noodle**
Seen a healthcare provider or received treatment, or have an appointment scheduled: **Yes**
Types of condition(s) treated for or will be seen for: **Physical**

Add ✓ Doctors or Healthcare Providers

Click the "Add" button if you need to enter information for a new doctor or healthcare provider.

Edit ✓ Doctor 1

Doctor or Healthcare Provider Details
Name of Doctor or Health Care Provider: **Johnny Walker**
Name of Practice or Medical Group: **Hypopotamus Clinic**
Phone Number: **(410) 998-3434**
Address: **1234 First Street, Baltimore, Maryland, 21201**
Patient ID Number, if known:

Treatment Dates
First Visit: **June 2019**
Last Visit:
Next Scheduled Appointment:

Medical Conditions Treated
Medical conditions treated: **Here go some medical conditions...**

Treatment Received
Treatments Received: **Here go some received treatments for the medical conditions received as stated above...**

Add ✓ Hospitals and Clinics

Click the "Add" button if you need to enter information for a new hospital or clinic.

Edit ✓ Hospital 1

Hospital or Clinic Details
Name of Hospital or Clinic: **First Hospital**
Name of Healthcare Provider who treated you: **John Dootorov**
Phone Number: **(410) 998-3434**
Address: **1234 First Street, Baltimore, Maryland, 21201**
Patient ID number: **123**

Treatment Dates
Outpatient Visits: **Yes**
First Visit: **June 2019**
Last Visit: **July 2019**
Next Visit: **July 2020**
Emergency Room Visits: **No**
Inpatient Stays: **No**

Medical Conditions Treated
Medical conditions treated: **Some remarks go here**

Treatment Received
Treatment Received: **Here go some received treatments**

Add ✓ Tests

Click the "Add" button if you need to enter information for a new test.

Edit ✓ Test 1

Test Type: **Blood Test (Not HIV)**
Date(s) of Test: **May 2019**
Who ordered this test? **I don't know**

Add ✓ Medicines

Click the "Add" button if you need to enter information for a new medicine.

Edit ✓ Medicine 1

Medicine Name: **Aspirin**
Reason: **Joint Pain**
Side Effects: **Nausea**
Prescribed by: **No one recommended or prescribed this medicine**

Add ✓ Other Medical Information

Click the "Add" button if you need to enter information for a new other medical information.

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

Date(s) of Test: **May 2019**

Who ordered this test? **I don't know**

Add ✔ Medicines

Click the "Add" button if you need to enter information for a new medicine.

Edit ✔ Medicine 1

Medicine Name: **Aspirin**

Reason: **Joint Pain**

Side Effects: **Nausea**

Prescribed by: **No one recommended or prescribed this medicine**

Add ✔ Other Medical Information

Click the "Add" button if you need to enter information for a new other medical information.

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

Edit ✔ Other Medical Information 1

Details of Other Medical Information

Name of Organization: **Hialia**

Claim or ID Number: **12345**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Name of Contact Person: **Fred Elmo**

Phone Number: **(410) 326-8778**

Contacts with this Organization

Date of First Contact: **June 15, 2018**

Date of Last Contact: **June 15, 2019**

Date of Next Contact: **June 15, 2020**

Reason for Contacts: **Some Visit Reason remarks go in here...**

Activities/Training

Edit ✔ Activities

Changes in daily activities due to physical or mental conditions: **Yes**

Describe the changes in daily activities: **Here go some remarks...**

Edit ✔ Work and Education

Have you worked or has your work changed: **No**

Completed or enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes: **Yes**

Type of training: **Training type**

Date(s) attended: **Sept 2017-May 2020**

Degree(s) attained, if any: **Training degree**

Date of attainment: **May 2020**

Edit ✔ Vocational Rehabilitation, Employment, or Other Support Services

Participated in program: **Yes**

Name of Organization or School: **Some Vocational Rehab Name**

Name of Counselor, Instructor, or Job Coach: **Curt Coachy**

Phone Number: **(410) 326-8778**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Date started participating: **10/12/2014**

Review

Edit ✔ Remarks

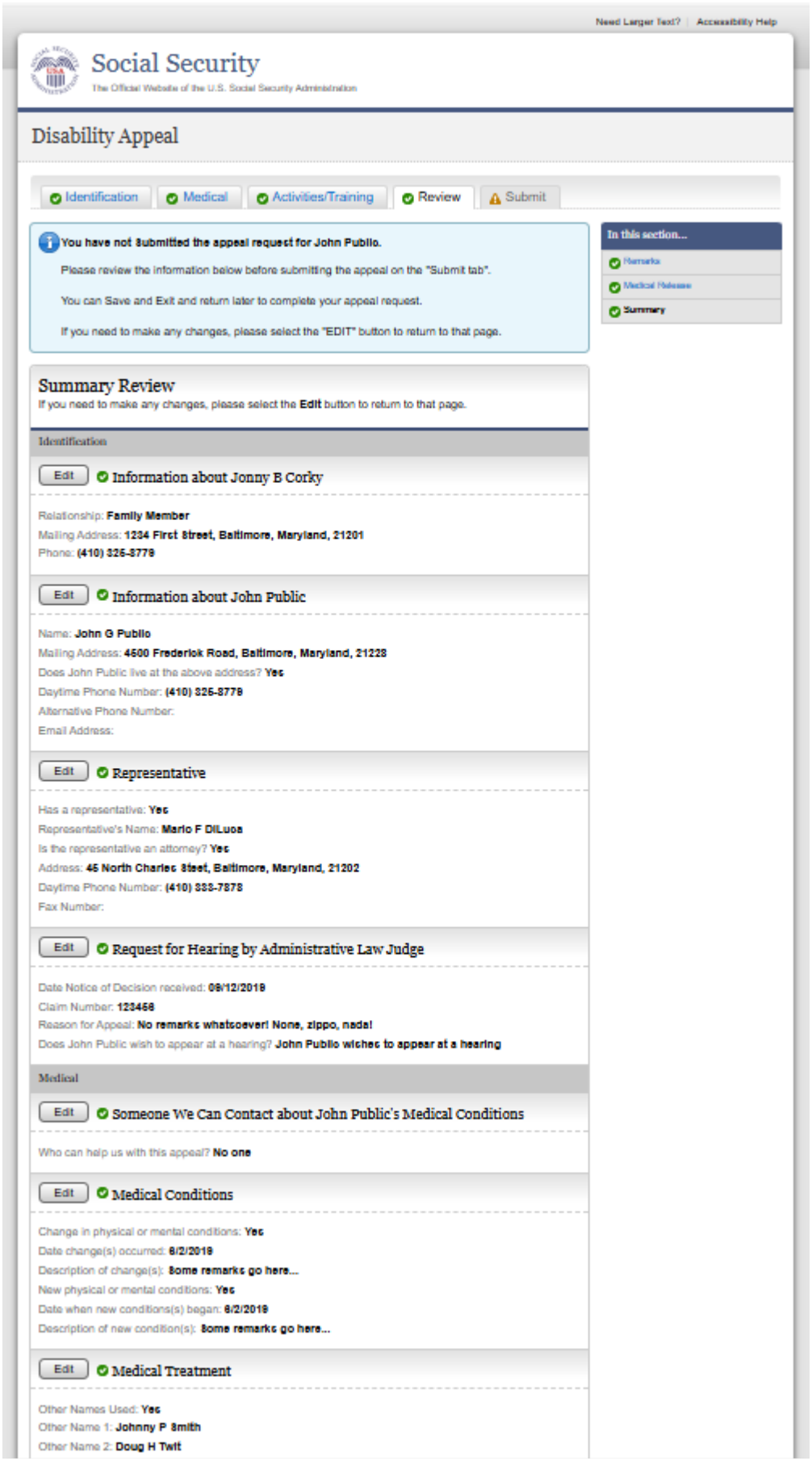
Remarks: **Some remarks go in here...**

Edit ✔ Medical Release Form

I voluntarily authorize and request disclosure of all of my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Agreed to electronically sign the medical release form.**

Next Previous Save & Exit

3rd Party: Summary (Revw001-3)



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Social Security
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Disability Appeal

Identification | Medical | Activities/Training | Review | Submit

You have not submitted the appeal request for John Public.

Please review the information below before submitting the appeal on the "Submit tab".

You can Save and Exit and return later to complete your appeal request.

If you need to make any changes, please select the "EDIT" button to return to that page.

In this section...
- Remarks
- Medical Release
- Summary

Summary Review

If you need to make any changes, please select the **Edit** button to return to that page.

Identification

Edit — Information about Jonny B Corky

Relationship: **Family Member**
Mailing Address: **1234 First Street, Baltimore, Maryland, 21201**
Phone: **(410) 325-8779**

Edit — Information about John Public

Name: **John G Public**
Mailing Address: **4500 Frederick Road, Baltimore, Maryland, 21228**
Does John Public live at the above address? **Yes**
Daytime Phone Number: **(410) 325-8779**
Alternative Phone Number:
Email Address:

Edit — Representative

Has a representative: **Yes**
Representative's Name: **Mario F DiLuca**
Is the representative an attorney? **Yes**
Address: **45 North Charles Street, Baltimore, Maryland, 21202**
Daytime Phone Number: **(410) 333-7878**
Fax Number:

Edit — Request for Hearing by Administrative Law Judge

Date Notice of Decision received: **08/12/2019**
Claim Number: **123456**
Reason for Appeal: **No remarks whatsoever! None, zippo, nada!**
Does John Public wish to appear at a hearing? **John Public wishes to appear at a hearing**

Medical

Edit — Someone We Can Contact about John Public's Medical Conditions

Who can help us with this appeal? **No one**

Edit — Medical Conditions

Change in physical or mental conditions: **Yes**
Date change(s) occurred: **6/2/2019**
Description of change(s): **Some remarks go here...**
New physical or mental conditions: **Yes**
Date when new conditions(s) began: **6/2/2019**
Description of new condition(s): **Some remarks go here...**

Edit — Medical Treatment

Other Names Used: **Yes**
Other Name 1: **Johnny P Smith**
Other Name 2: **Doug H Twit**

Other Name 5: **Doodle N Noodle**

Seen a healthcare provider or received treatment, or have an appointment scheduled: **Yes**

Types of condition(s) treated for or will be seen for: **Physical**

Add ✓ Doctors or Healthcare Providers

Click the "Add" button if you need to enter information for a new doctor or healthcare provider.

Edit ✓ Doctor 1

Doctor or Healthcare Provider Details

Name of Doctor or Health Care Provider: **Johnny Walker**

Name of Practice or Medical Group: **Hypopotamus Clinic**

Phone Number: **(410) 888-3434**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Patient ID Number, if known:

Treatment Dates

First Visit: **June 2019**

Last Visit:

Next Scheduled Appointment:

Medical Conditions Treated

Medical conditions treated: **Here go some medical conditions...**

Treatment Received

Treatments Received: **Here go some received treatments for the medical conditions received as stated above...**

Add ✓ Hospitals and Clinics

Click the "Add" button if you need to enter information for a new hospital or clinic.

Edit ✓ Hospital 1

Hospital or Clinic Details

Name of Hospital or Clinic: **First Hospital**

Name of Healthcare Provider who treated you: **John Doctorov**

Phone Number: **(410) 888-3434**

Address: **1234 First Street, Baltimore, Maryland, 21201**

Patient ID number: **123**

Treatment Dates

Outpatient Visits: **Yes**

First Visit: **June 2019**

Last Visit: **July 2019**

Next Visit: **July 2020**

Emergency Room Visits: **No**

Inpatient Stays: **No**

Medical Conditions Treated

Medical conditions treated: **Some remarks go here**

Treatment Received

Treatment Received: **Here go some received treatments**

Add ✓ Tests

Click the "Add" button if you need to enter information for a new test.

Edit ✓ Test 1

Test Type: **Blood Test (Not HIV)**

Date(s) of Test: **May 2019**

Who ordered this test? **I don't know**

Add ✓ Medicines

Click the "Add" button if you need to enter information for a new medicine.

Edit ✓ Medicine 1

Medicine Name: **Aspirin**

Reason: **Joint Pain**

Side Effects: **Nausea**

Prescribed by: **No one recommended or prescribed this medicine**

Add ✓ Other Medical Information

Date(s) of Test: **May 2019**
Who ordered this test? **I don't know**

Add ✓ Medicines

Click the "Add" button if you need to enter information for a new medicine.

Edit ✓ Medicine 1

Medicine Name: **Aspirin**
Reason: **Joint Pain**
Side Effects: **Nausea**
Prescribed by: **No one recommended or prescribed this medicine**

Add ✓ Other Medical Information

Click the "Add" button if you need to enter information for a new other medical information.

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (including emotional and learning problems) or are you scheduled to see anyone else? **Yes**

Edit ✓ Other Medical Information 1

Details of Other Medical Information
Name of Organization: **Hialia**
Claim or ID Number: **12345**
Address: **1234 First Street, Baltimore, Maryland, 21201**
Name of Contact Person: **Fred Elmo**
Phone Number: **(410) 326-3778**

Contacts with this Organization
Date of First Contact: **June 15, 2019**
Date of Last Contact: **June 15, 2019**
Date of Next Contact: **June 15, 2020**
Reason for Contacts: **Some Visit Reason remarks go in here...**

Activities/Training

Edit ✓ Activities

Changes in daily activities due to physical or mental conditions: **Yes**
Describe the changes in daily activities: **Here go some remarks...**

Edit ✓ Work and Education

Have you worked or has your work changed: **No**
Completed or enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes: **Yes**
Type of training: **Training type**
Date(s) attended: **Sept 2017-May 2020**
Degree(s) attained, if any: **Training degree**
Date of attainment: **May 2020**

Edit ✓ Vocational Rehabilitation, Employment, or Other Support Services

Participated in program: **Yes**
Name of Organization or School: **Some Vocational Rehab Name**
Name of Counselor, Instructor, or Job Coach: **Curt Cosohy**
Phone Number: **(410) 326-3778**
Address: **1234 First Street, Baltimore, Maryland, 21201**
Date started participating: **10/12/2014**

Review

Edit ✓ Remarks

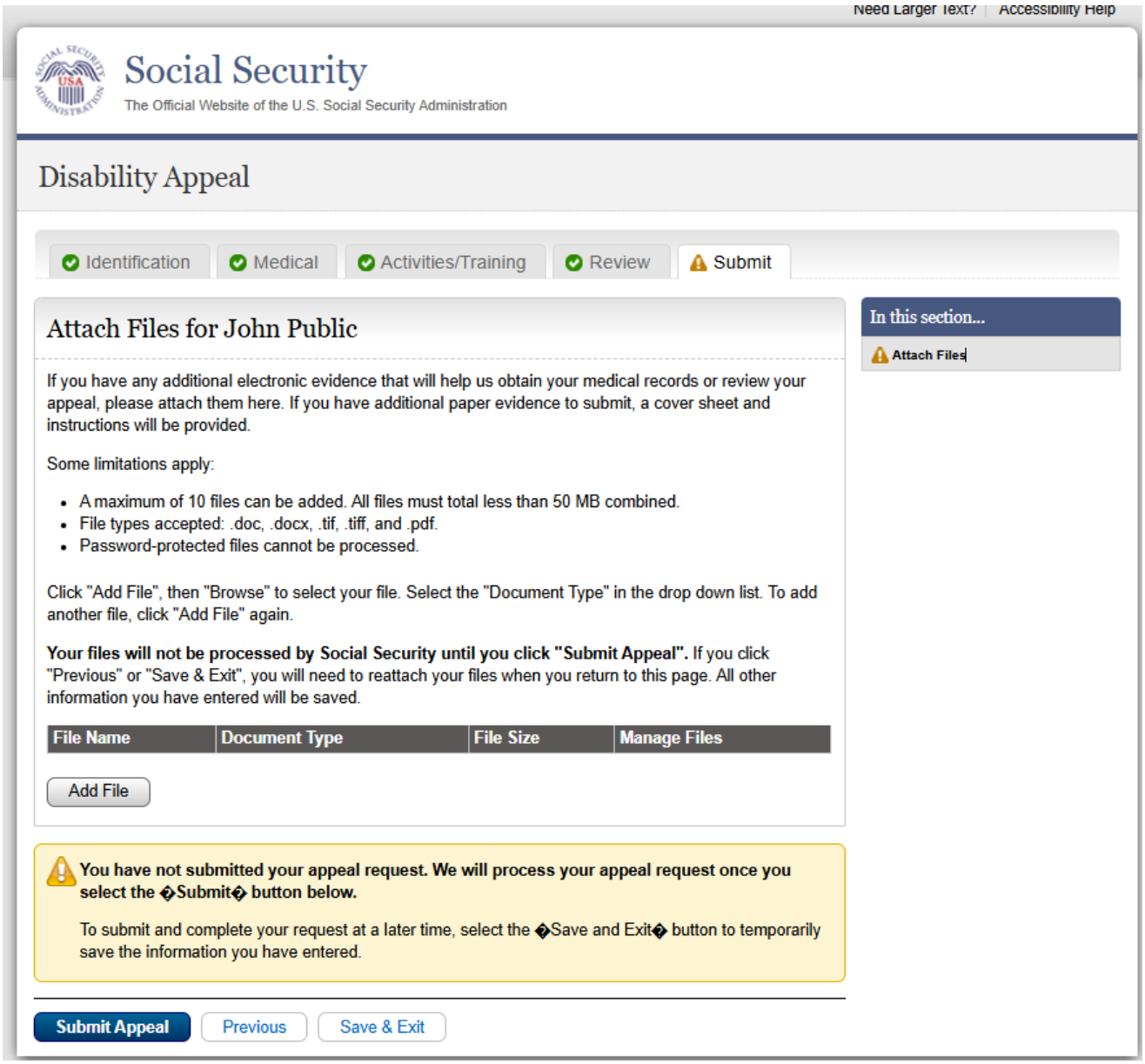
Remarks: **Some remarks go in here...**

Edit ✓ Medical Release Form

I voluntarily authorize and request disclosure of all of my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Agreed to electronically sign the medical release form.**

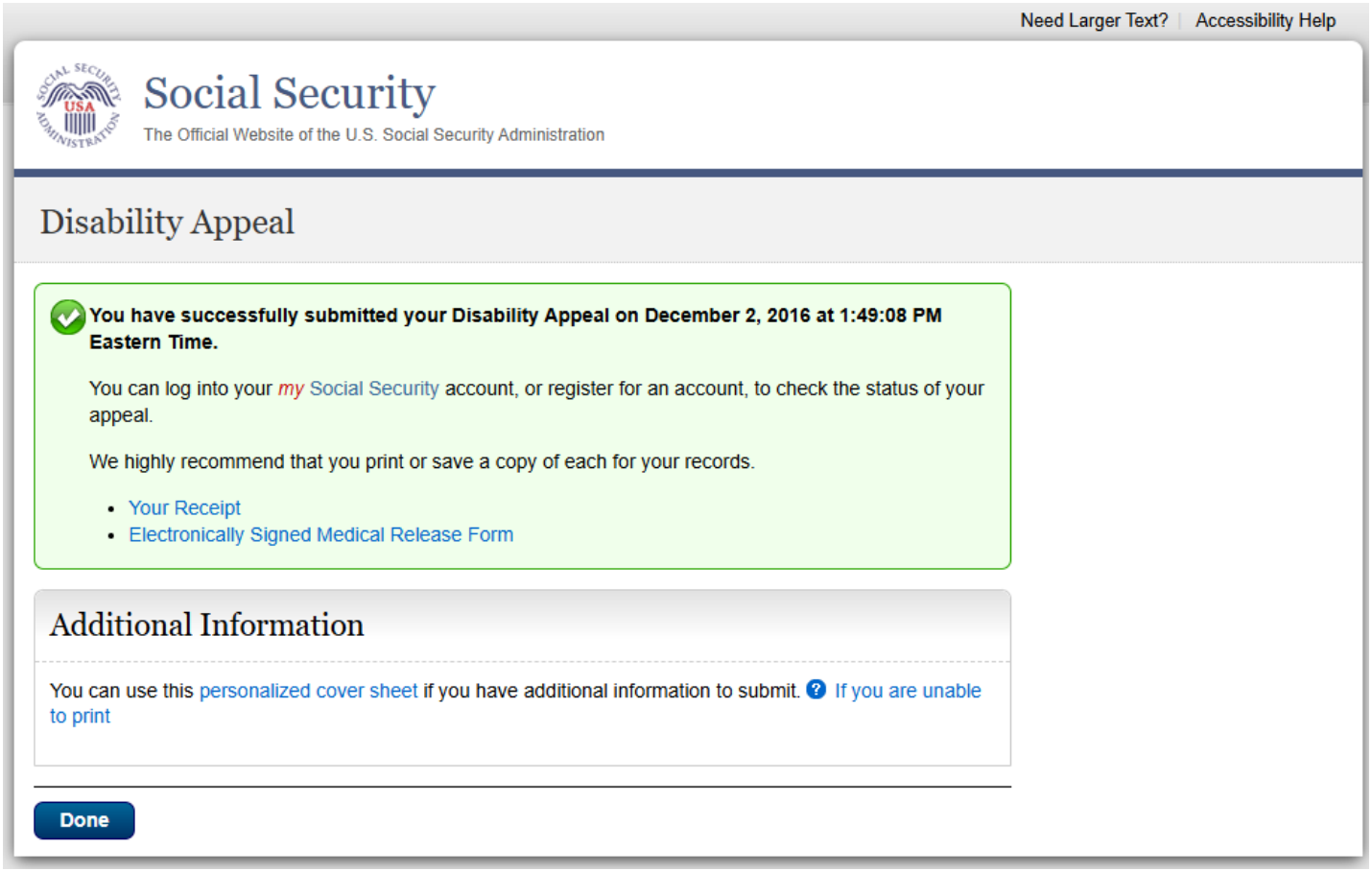
Next | Previous | Save & Exit

1st Party: File Attachment (Flup001-1)

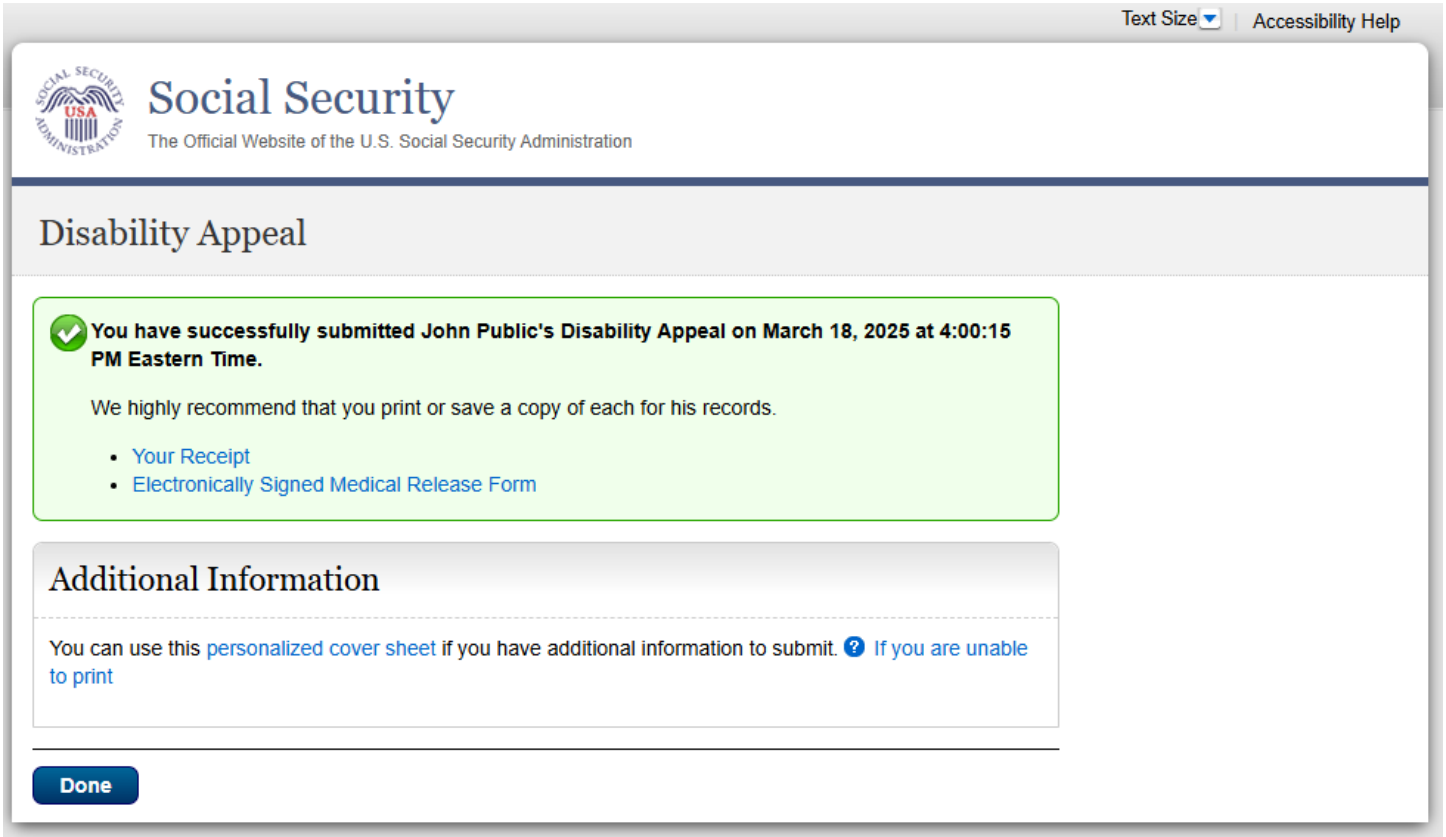


3rd Party: File Attachment (Flup001-3)

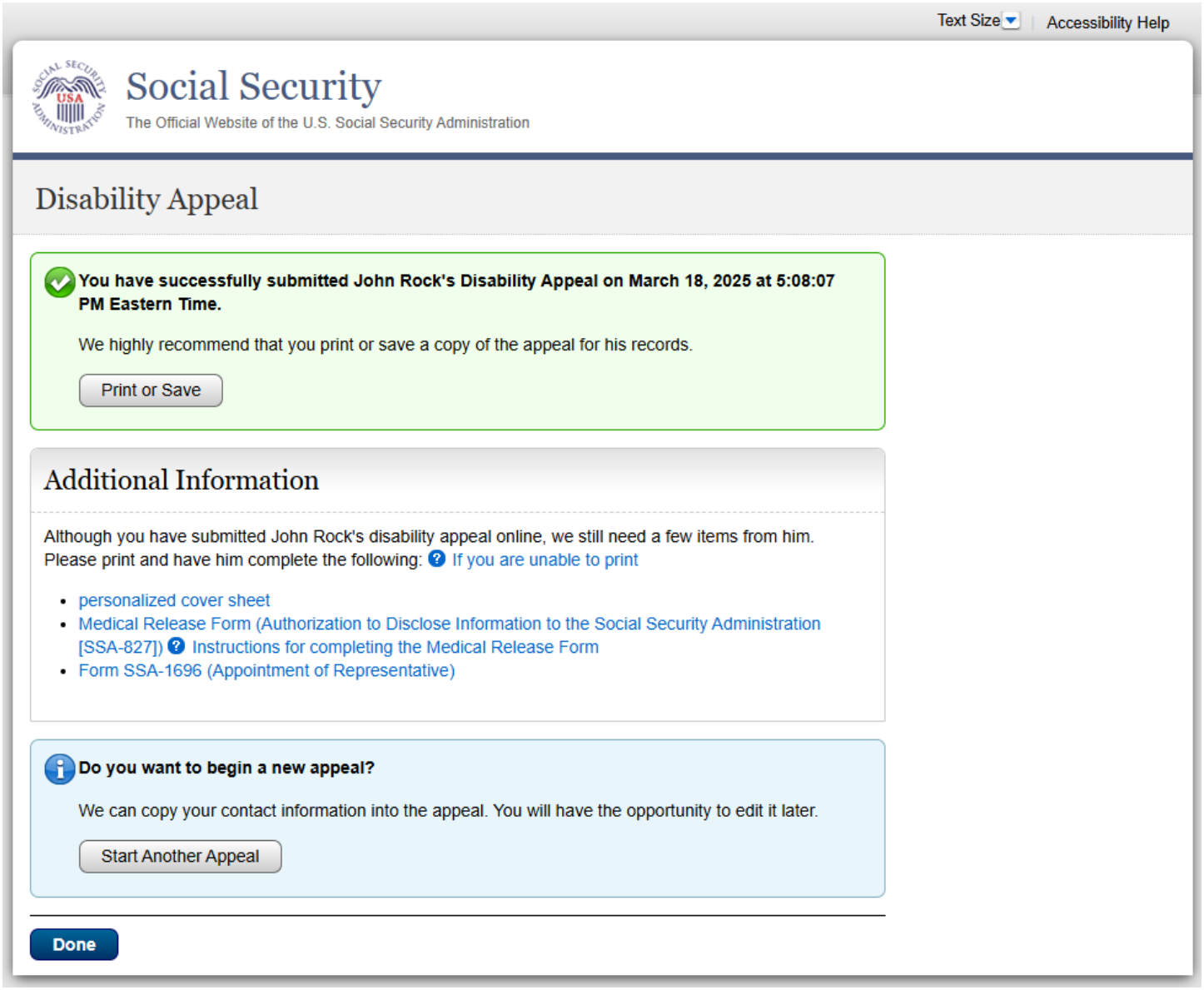
1st Party: Application Submission Confirmation (Conf001-1)



3rd Party: Application Submission Confirmation (Conf001-3)



3rd Party - Appointed Representative: Application Submission Confirmation (Conf001-3-Rep)



Receipt (Rcpt001)

You have successfully submitted your Disability Appeal on March 18, 2025 at 4:00:15 PM Eastern Time.

We may review John Public's case to determine if we can make a decision without a hearing. If we determine he needs a hearing, we will appoint an Administrative Law Judge to conduct the hearing. We will provide advance notice of the time and place of hearing. The hearing office assigned to this case will also send John Public more information regarding his appeal.

Information You Submitted for John Public

Identification

Information about Sam Washington

Relationship: **Family Member**
Mailing Address: **741 Main St, Baltimore, Maryland, 21117**
Phone:

Information about John Public

Name: **John Q Public**
Mailing Address: **741 Main St, Baltimore, Maryland, 21117**
Does John Public live at the above address? **Yes**
Daytime Phone Number:
Alternative Phone Number:
Email Address:

Representative

Has a representative: **No**

Request for Hearing by Administrative Law Judge

Date Notice of Decision received: **03/10/2025**
Claim Number:
Reason for Appeal: **because**
Does John Public wish to appear at a hearing? **John Public wishes to appear at a hearing**

Medical

Someone We Can Contact about John Public's Medical Conditions

Who can help us with this appeal? **Sam Washington**

Medical Conditions

Change in physical or mental conditions: **No**
New physical or mental conditions: **No**

Medical Treatment

Other Names Used: **No**
Seen a healthcare provider or received treatment, or have an appointment scheduled: **No**

Doctors or Healthcare Providers

No doctors or healthcare providers entered.

Hospitals and Clinics

No hospitals or clinics entered.

Tests

No tests entered.

Medicines

No medicines entered.

Other Medical Information

Since you last told us about your other medical information, does anyone have medical information about any of your physical or mental conditions (Including emotional and learning problems) or are you scheduled to see anyone else? **No**

Activities/Training

Activities

Changes in daily activities due to physical or mental conditions: **No**

Work and Education

Have you worked or has your work changed: **No**
Completed or enrolled in any type of GED classes, specialized job training, trade school, vocational school or college classes: **No**

Vocational Rehabilitation, Employment, or Other Support Services

Participated in program: **No**

Review

Remarks

Remarks:

Medical Release Form

I voluntarily authorize and request disclosure of all of my medical records; also education records and other information related to my ability to perform tasks. I agree to: **Agreed to electronically sign the medical release form.**

Electronically Signed Medical Authorization (Form827)

Form **SSA-827** (03-2020)
Discontinue Prior Editions

OMB No. 0960-0623

Whose Records to be Disclosed

NAME (*First, Middle, Last, Suffix*)
John Q Public

SSN
***-**-7222

Birthday *(MM/DD/YYYY)*
05/25/1977

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:

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 Signature

Electronically signed by:
John Q Public

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
03/19/2025

Street Address
741 Main St

Phone Number (with area code)

City
Baltimore

State
MD

ZIP
21117

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

Signature

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

Phone Number (or Address)

Phone Number (or Address)

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), 223(d), and 1631(d) 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 your claim that could result in a denial or loss of benefits.

We will use the information you provide to determine your eligibility or continuing eligibility for benefits, and your ability to manage any benefits that you currently receive.

We may also share your information for the following purposes, called routine uses:

1. To State audit agencies for auditing State supplementation payments and Medicaid eligibility considerations;
2. To third party contacts where necessary to establish or verify information provided by representative payees or payeee applicants; and
3. To Federal, State or local agencies for administering cash or non-cash income maintenance or health maintenance 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 (SORNs) 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 60-0320, entitled Electronic Disability; and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. 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 control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

Cover Sheet (Covr001)

Cover Sheet for John Public

BNC: 25VZ271B09375

I have completed the appeal for disability benefits online. I understand that the appeal I completed and sent to Social Security electronically will be used in making a decision on John Public's claim for benefits.

John Public's address:
741 Main St
Baltimore, MD 21117

John Public's phone number:

Name and address of someone else Social Security can contact who knows about John Public's condition:
Sam Washington
741 Main St
Baltimore, MD 21117

I have attached the following items (check all that apply):

- ☐ Copies of Medical Records You Already Have
- ☐ Other (Please list below)

_____

_____

_____

Mail or bring to:
SOCIAL SECURITY
315 N WASHINGTON ST
ROCKVILLE , MD 20850-1750