REQUEST FOR CORRECTIVE ACTION

1. IDENTIFYING DATA

TO:	Office Code	Social Security Number _ _
		Name of Disabled Person
FROM:	Office Code	NH
		DATE

2. DETERMINATION LEVEL	3. TYPE OF CLAIMANT/BENEFICIARY		4. TYPE OF REVIEW
	TITLE II	TITLE XVI	
☐ INITIAL ☐ RECON ☐ CDR ☐ CDR RECON ☐ REOPEN	☐ DIB ☐ DWB ☐ CDB ☐ MEDICARE ONLY ☐ OTHER	☐ DI ☐ DS ☐ DC ☐ BI ☐ BS ☐ BC	☐ QA ☐ PER ☐ OTHER

5. DECISION	6. DIAGNOSIS	7. ONSET	8. GROUP II DEFICIENCY
☐ FAVORABLE ☐ UNFAVORABLE	PRIMARY - SECONDARY -	AOD EOD ROD	DECISIONAL ☐ DOCUMENTATION ☐ NONE CHARGED ☐

9. REFERENCES

☐ Do not return file to DQB

☐ Return File to DQB

10. DEFICIENCY TYPE **Please see attached medical and/or vocational comments**

☐ **Decisional Deficiency**

☐ Evidence supports earlier onset or cessation date.

☐ Evidence supports later onset or cessation date.

☐ Work activity issue incorrectly handled.

☐ Onset invades period of ALJ/AC decision.

☐ Evidence supports reopening prior decision.

☐ Incorrect DWB control date.

☐ Other (See below)

☐ **Documentation Deficiency**

☐ Medical evidence does not support DOD. Additional evidence needed.

☐ Earlier onset possible.

☐ EOD invades prior adjudicated period, prior file needed.

☐ Insufficient documentation to support the cessation date.

☐ Development of work activity needed before onset can be determined.

☐ Vocational evidence does not support EOD. Additional evidence needed.

☐ Other (See below)

ACTION REQUESTED AND/OR RATIONALE

FOLDER ATTACHED ☐ YES ☐ NO ☐ *Continued on Attached Sheet*

EXAMINER'S SIGNATURE	DATE	REVIEWER'S SIGNATURE	DATE

Form **SSA-1774-OP** (03-2006) ef (06-2006) (5 Copies: Transmittal, Official folder, Review component, Regional disability program, Field office)