REQUEST FOR ASSISTANCE - DISABILITY

(Check One)

☐ PRIORITY ☐ REGULAR

DO/BO USE

☒ TO (DO/BO City and State)

☒ DO/BO CODE

NUMBER HOLDER

☒ NUMBER HOLDER (NH)

☒ CLAIM NO. (SSN, BIC/ARC)

☐ TITLE II
☐ TITLE XVI
☐ TITLE II,XVI

☐ BENEFICIARY

☐ BENEFICIARY'S OWN SSN

☒ CONTACT

☐ NH ☐ BENEFICIARY ☐ PAYEE Name ____ Relationship

☐ ATTORNEY ☐ OTHER ____

☒ ADDRESS (Include zip code)

☒ TELEPHONE NUMBER (include area code)

☐ NOT IN FILE
☐ DIRECT CONTACT ATTEMPTED

☒ STATUS OF ____ FOLLOWS:

☐ AWARD EFF ____ ☐ IN CURRENT PAY ☐ PYMT SUSP EFF ____

☐ NO AWARD PENDING YOUR ACTION ☐ PYMT DEFER'D TO ____ ☐ PYMT TERM EFF ____

☐ LATEST DISABILITY DETERMINATION MADE
☐ BASED ON APPLIC. DATED ____
☐ DUE TO CDI DATED ____

☐ DECISION BY DDS ____
DDS CODE ____ DATE ____ FILE NO. ____

☐ FURNISH STATUS ON ☐ SSA-5526-U3 ☐ MEMO
☐ SSADARS MSG DATED ____
☐ ADDITIONAL INFORMATION NEEDED TO ADJUDICATE CLAIM
☐ FIELD CDI NEEDED - WORK
- ☐ NOT ENTITLED TO A TRIAL WORK PERIOD
- ☐ TRIAL WORK PERIOD EXPIRED ____
- ☐ WORKED ____ MONTHS IN TRIAL WORK PERIOD
- ☐ INVESTIGATE WORK ACTIVITY FROM ____
- ☐ VOLUNTARY REPORT OF WORK ACTIVITY RECEIVED
- ☐ EARNINGS POSTED FOR ____
- ☐ OBTAIN MONTHLY BREAKDOWN OF EARNINGS FROM ____ TO ____

☐ EPE CASE
- ☐ MEDICAL ISSUE
- ☐ NO MEDICAL ISSUE

☐ PAST DUE MEDICAL REEXAM - PLEASE EXPEDITE
☐ MEDICAL FOLDER REVIEW NOT DONE, FORWARD CASE TO DDS FOLLOWING SGA CESSATION OR TO ____ FOLLOWING A CONTINUANCE

☐ DISCUSS RSI CLAIM, DOB ____
☐ FIELD CDI NEEDED--MEDICAL
- ☐ FACE-TO-FACE INTERVIEW REQUIRED
- ☐ PERIODIC REVIEW
- ☐ MEDICAL REEXAM DIARY HAS COME DUE
- ☐ EVIDENCE RECEIVED INDICATES MEDICAL IMPROVEMENT
- ☐ VOCATIONAL INFORMATION NOT OBTAINED INITIALLY IN ADDITION TO THE USUAL CDI DEVELOPMENT, PROVIDE A COMPLETE VOCATIONAL DESCRIPTION WHEN THERE IS AN ISSUE OF MEDICAL IMPROVEMENT AND WORK IS NOT BEING PERFORMED AT THE SGA LEVEL
- ☐ PREPARE CONT. OR CESS., PER ____

☐ PROVIDE DUE PROCESS, PER ____
- ☐ REQUEST SUSPENSION ACTION, IF APPROPRIATE,PER REFERENCE BELOW
- ☐ BENEFIT PAYMENTS HAVE BEEN SUSPENDED

☐ TAKE ACTION ON ATTACHED CORRESPONDENCE
☐ RESPOND TO ☐ ODO ☐ DDS ☐ ____ PSC ☐ OIO

USE REVERSE AS TRANSMITTAL

CLAIM NUMBER

☐ Text continued on SSA-5524A-U3

☒ PROCEDURAL REFERENCES (List)

☐ ATTACHMENTS (List)
☐ DISABILITY FOLDER ☐ ____

☒ FROM

☒

☐ ____ PSC ☐ OIO ☐ ODO ☐ MOD ____ ☐ ____

☒ "PARENT" FOLDER'S SSN

☒ BY (Print name)

☐ CA
☐ ____

☐ XREF SSN (Optional)

☒ FTS NUMBER	☒ COMM. NO. (include area code)	☒ DATE OF REQUEST	☒ DIARY DUE DATE	☒ TYPE-OF-EVENT CODE	
				TOEL1	TOEL2

Form **SSA-5526-U3** (11-92) EF (8-99)
Prior Editions May Be Used

DO/BO COPY

REPLY TO REQUEST FOR ASSISTANCE - DISABILITY

(DO/BO - Complete first two lines with information from front of this form.)

☒ TO ☐ OIO ☒ ATTENTION
☐ _____PSC ☐ ODO ☐ DDS ☐ MOD _____ ☐ _____

☒ "PARENT" FOLDER'S SSN

☐ PERIODIC REVIEW ☐ SCHEDULED MEDICAL REEXAM
☐ EPE CASE (MEDICAL ISSUE)

☒ TYPE-OF-EVENT CODE
TOEL1 | TOEL2

DATE	RECORD OF ACTION TAKEN AND INFORMATION RECEIVED
	☐ CDI FACE-TO-FACE INTERVIEW COMPLETED ON

☐ ATTACHMENTS (List)

☒ FROM (DO/BO City and State)

☒ DO/BO CODE

☒ BY (Print name)

☐ CR ☐ SR
☐ FR ☐

☒ PHONE ☐ FTS ☐ ( )

☒ DATE OF RESPONSE