Claimant: Arthur Miller | SSN: 456-12-7890 Level: Hearing | Claim type: T16
Alleged onset: 07/01/2022 | Last Insured: Application: 07/14/2022 | Last Changed: 05/21/2024

A. Payment Documents/Decisions

Title	Decision Date	Pg
1A: Disability Determination Explanation - DDE	Received: Prior to Hearing	15
2A: Disability Determination Transmittal - 831	Received: Prior to Hearing	1
3A: Disability Determination Explanation - DDE	Received: Prior to Hearing	8
4A: Disability Determination Transmittal - 831	Received: Prior to Hearing	1

B. Jurisdictional Documents/Notices

Title	Document Date	Pg
1B: SSA-1696 - Claimant's Appointment of a Representative - 1696	07/14/2022	4
2B: Fee Agreement for Representation before SSA - FEEAGRMT	07/14/2022	1
3B: T16 Notice of Disapproved Claim - L444	04/28/2023	6
4B: Informal Request for Reconsideration - INFRECON	05/12/2023	1
5B: T16 Disability Reconsideration Notice - L1130	08/30/2023	4
6B: T16 Disability Reconsideration Notice - L1130	08/30/2023	4
7B: Hearing Agreement Form - HRNGAGREEFRM	09/08/2023	1
8B: Informal Request for Hearing by ALJ - INFHEAR	09/08/2023	1
9B: Outgoing ODAR Correspondence - OUTODARC	09/28/2023	4
10B: Request for Hearing Acknowledgement Letter - HRGACK	09/29/2023	19
11B: Hearing Notice - 507	02/05/2024	14
12B: Acknowledge Notice of Hearing - 504	03/05/2024	6
13B: Notice Of Hearing Reminder - HA503	05/06/2024	4
14B: Hearing Agreement Form - HRNGAGREEFRM	05/20/2024	1

D. Non-Disability Development

Title	Document Date	Pg
1D: Lead Protective Filing Worksheet - LPFWKSHT	07/14/2022	3
2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG	07/27/2022	13
3D: Application for Supplemental Security Income Benefits - 8000	08/15/2022	7
4D: Certified Earnings Records - CERTERN	02/26/2024	3
5D: Summary Earnings Query - SEQY	02/26/2024	2
6D: Detailed Earnings Query - DEQY	02/26/2024	9
7D: New Hire, Quarter Wage, Unemployment Query (NDNH) - NDNH	02/26/2024	1

E. Disability Related Development

Title	Source	Treatment Date	Pg
1E: Disability Report - Field Office - 3367	FO	08/15/2022	2
2E: Work History Report - 3369	Arthur Miller	08/15/2022	7
3E: Disability Report - Adult - 3368	Eleanor R Walker	08/15/2022	7
4E: Function Report - Adult - 3373	Arthur Miller	12/09/2022	9
5E: Disability Report - Appeals - 3441	Eleanor R Walker	05/18/2023	6
6E: Disability Report - Field Office - 3367	FO	05/18/2023	2

E. Disability Related Development - cont.

Title	Source	Treatment Date	Pg
7E: Function Report - Adult - 3373	Arthur Miller	07/26/2023	8
8E: Disability Report - Appeals - 3441	Emily Miller	09/21/2023	6
9E: Disability Report - Field Office - 3367	FO	09/21/2023	2
10E: Exhibit List to Rep PH2E - EXHIBITLISTREP	Cityville Appeals Office	02/29/2024	21
11E: Representative Correspondence - REPLTR	Legal Advocates for the Disabled	04/02/2024	1

Title	Source	Treatment Date	Pg
12E: Resume of Vocational Expert - VERESUM	MARIA RODRIGUEZ	05/14/2024	2
13E: Correspondence regarding efforts to obtain evidence - EALTR	Appeals Division	05/20/2024	1

F. Medical Records

Title	Source	Treatment Date	Pg
1F: Medical Source - No MER Available - MEDNOMER	METRO HEALTH & WELLNESS #1	01/16/2023	6
2F: Hospital Records - HOSPITAL	Willow Creek Medical Center	09/15/2022-01/18/2023	19
3F: Office Treatment Records - OFFCREC	METRO HEALTH & WELLNESS #2	09/15/2022-01/26/2023	11
4F: HIT MER - HITMER	Unity Care Clinic	02/09/2023	3
5F: Hospital Records - HOSPITAL	Central Plains Medical Center	01/27/2023-02/09/2023	91
6F: Office Treatment Records - OFFCREC	METRO WELLNESS CLINIC	01/26/2023-04/13/2023	14
7F: Medical Source - No MER Available - MEDNOMER	METRO WELLNESS CLINIC	04/20/2023	12
8F: Office Treatment Records - OFFCREC	Sterling Health Clinic	07/21/2021-07/06/2023	34
9F: HIT MER - HITMER	Unity Care Clinic	02/26/2024	3
10F: Office Treatment Records - OFFCREC	Sterling Health Clinic	07/06/2023-07/07/2023	16

Disability Determination Explanation

This Disability Determination Explanation is for the DI claim at the Initial level.

CLAIMANT INFORMATION

Name: Arthur Miller SSN: 456-12-7890 Phone Number: (773) 555-9876 Secondary Phone Number Address:

Mailing	Residence
789 OAK AVE CHICAGO, IL 60601	789 OAK AVE CHICAGO, IL 60601 - 1001

Claimant Gender: M Self Reported Height: 65 inches Self Reported Weight: 160.0 lbs BMI: 26.6 Special Indications: None.

RELEVANT DATES

Below table represents the Relevant Dates

Date of Birth	Current Age	AOD	Age at AOD	DFI DLI	Age at DLI	Blind DLI
05/21/1965	57 years 11 months (Advanced age)	07/01/2022	57 years 1 month (Advanced age)			

Back to top 2 of 15: 1A: Disability Determination Explanation - DDE

Does the individual have an attorney/appointed representative? Yes

Representative's name, address and phone number: Eleanor Rose Walker 1789 MAIN STREET STE 201 ANYTOWN, CA 90210 (310) 555-0189

ALLEGATIONS OF IMPAIRMENTS

The individual filed for Initial claim for disability on 07/14/2022 due to the following illnesses, injuries or conditions: Car accident in 2012; Chronic hip pain;

Nerve damage related to neck area; Insomnia due to pain; Difficulty sitting and standing; Herniated discs in back; LEFT SIDE OF BODY WENT NUMB;

The individual alleges inability to function and/or work as of 07/01/2022

TECHNICAL ISSUES

Is the individual working? No

Is Presumptive Disability/Presumptive Blindness appropriate for this claim? No

Prior Electronic Filings

Prior Electronic Filing	Claim Level	Claim Type	Initial Status Application Filing Date	Protective Filing Date	Determination or Decision Date	AC Remand Date
1	Initial	DI	Closed06/18/2013		10/01/2013	

Disclaimer: The Determination or Decision Date in the table above is propagated from the Decision Date field in eView, and may be later than the date on the Determination or Decision notice. A Determination or Decision (initial or revised) is final as of the date of the notice. Refer to DI 27501.001A for exceptions.

Back to top 3 of 15: 1A: Disability Determination Explanation - DDE

Alleged Onset Date: 07/01/2022

Has the individual performed work after the Alleged Onset Date(AOD)? No

Has any period(s) of work been determined to be an unsuccessful work attempt, or involved subsidies/special conditions, impairment-related work expenses, or other technical issue(s)? No

EVIDENCE OF RECORD

The following initial evidence has been received

Source of Evidence: METRO WELLNESS CLINIC EF Received: 04/26/2023 Medical Opinion: No Evidence Type: MER Level: Initial

Source of Evidence: METRO WELLNESS CLINIC EF Received: 04/19/2023 Medical Opinion: No Evidence Type: MER Level: Initial

Source of Evidence: Central Plains Medical Center EF Received: 03/08/2023 Medical Opinion: No Evidence Type: MER Level: Initial

Source of Evidence: Unknown Name EF Received: 02/22/2023

Back to top 4 of 15: 1A: Disability Determination Explanation - DDE

Medical Opinion No

Evidence Type	5002 ROC
Level	Initial

Source of Evidence Metro Health & Wellness Center

EF Received	02/17/2023
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence Unknown Name

EF Received	02/09/2023
Medical Opinion	No
Evidence Type	5002 ROC
Level	Initial

Source of Evidence Metro Health & Wellness Center

EF Received	02/09/2023
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence Unity Care Clinic

EF Received	02/09/2023
Medical Opinion	No
Evidence Type	HIT MER
Level	Initial

Source of Evidence Unknown Name

EF Received	02/06/2023
Medical Opinion	No
Evidence Type	5002 ROC
Level	Initial

Source of Evidence Unknown Name

EF Received	02/06/2023
Medical Opinion	No

Source of Evidence Unknown Name

Evidence Type	5002 ROC
Level	Initial

5 of 15: 1A: Disability Determination Explanation - DDE

Level	**Initial**
Source of Evidence	Unity Care Clinic
EF Received	02/06/2023
Medical Opinion	No
Evidence Type	HIT Response
Level	Initial

Source of Evidence Unity Care Clinic

EF Received	02/03/2023
Medical Opinion	No
Evidence Type	HIT Response
Level	Initial

Source of Evidence Unknown Name

EF Received	01/26/2023
Medical Opinion	No
Evidence Type	5002 ROC
Level	Initial

Source of Evidence Willow Creek Medical Center

EF Received	01/26/2023
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence Metro Health & Wellness Center

EF Received	01/18/2023
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence Unknown Name

EF Received	12/28/2022
Medical Opinion	No

Source of Evidence	**Unknown Name**
Evidence Type	5002 ROC
Level	Initial

Back to top 6 of 15: 1A: Disability Determination Explanation - DDE

Source of Evidence	**Unknown Name**
EF Received	12/13/2022
Medical Opinion	No
Evidence Type	5002 ROC
Level	Initial

Source of Evidence	**Unknown Name**
EF Received	12/09/2022
Medical Opinion	No
Evidence Type	3373-Funct Rprt-Adult
Level	Initial

Source of Evidence	**Unknown Name**
EF Received	08/15/2022
Medical Opinion	No
Evidence Type	3369-Work Hx
Level	Initial

Source of Evidence	**WELLNESS CONSULTANTS LTD**
EF Received	09/28/2013
Medical Opinion	No
Evidence Type	MER
Level	Initial

The following evidence has been requested:

Source of Evidence	**EF Request Date**	**Level**
Metro Health & Wellness Center	04/18/2023	Initial
Central Plains Medical Center	03/08/2023	Initial
Metro Health & Wellness Center	03/08/2023	Initial
Central Plains Medical Center	02/22/2023	Initial
Metro Health & Wellness Center	02/22/2023	Initial
Unknown Name	01/26/2023	Initial

Source of Evidence	EF Request Date	Level
Midwest Rehabilitation Center	01/19/2023	Initial
Willow Creek Medical Center	01/19/2023	Initial
Metro Health & Wellness Center	01/11/2023	Initial
Metro Health & Wellness Center	12/28/2022	Initial
Unknown Name	12/27/2022	Initial
Unknown Name	12/27/2022	Initial

Back to top 7 of 15: 1A: Disability Determination Explanation - DDE

Unknown Name	Date	Initial
Unknown Name	12/27/2022	Initial
Unknown Name	12/09/2022	Initial
Unknown Name	11/28/2022	Initial
Unknown Name	11/28/2022	Initial
Unknown Name	11/28/2022	Initial
Unknown Name	11/28/2022	Initial
RIVER CITY HEALTH CLINIC	11/10/2022	Initial
RIVER CITY HEALTH CLINIC	10/27/2022	Initial

CLAIM COMMUNICATIONS

No general claim communications have been created.

CONSULTATIVE EXAMINATION(S) (CE)

Is a CE(s) required?

No

FINDINGS OF FACT AND ANALYSIS OF EVIDENCE

Analysis

INITIAL:

Claimant is 57 years old, 12th grade education with past work.

Upon review of evidence it is determined claimant has NO MDI for mental and a light physical RFC (SEE PRTF/RFC).

A finding regarding the capacity for past relevant work has not been made. However, this information is not material because all potentially applicable med-voc guidelines direct a finding of not disabled given the claimant's age, education and RFC.

Claim denied.

---

416 - WELLNESS CONSULTANTS LTD

Back to top No 416-Medical Evaluation have been associated with this claim.

MEDICALLY DETERMINABLE IMPAIRMENTS AND SEVERITY (MDI)

ADULT MEDICALLY DETERMINABLE IMPAIRMENTS (MDI)

Does the individual have one or more medically determinable impairments? Yes

IMPAIRMENT

7150 - Osteoarthrosis and Allied Disorders

PRIORITY	SEVERITY
Primary	Severe

PSYCHIATRIC REVIEW TECHNIQUE (PRT)

PRT1

Indicate whether this Psychiatric Review Technique (PRT) assessment is for:
Current Evaluation

No mental medically determinable impairments established

PRT - ADDITIONAL EXPLANATION

INITIAL: Claimant is 58 years old. Primary allegations appear physical. CLMT also indicates he had problems reading math and comprehension in school. No school

MER available. Application notes he obtained a 12th grade education. Exams note he is oriented X 3 with calm mood/affect. There is no evidence of current participation in formal OP psych tx or use of psych Rx. ADLs - prepares simple meals; completes household chores; some personal care issues due to physical; walks, shops; watches TV and socializes. No MDI for mental issues.

These findings complete the medical portion of the disability determination.

MC/PC Signature

Dr. Elara Vance (038) 04/22/2023 9 of 15: 1A: Disability Determination Explanation - DDE

ADULT LISTINGS CONSIDERED

Listing	Description	Subsection
1.18	Abnormality of a Major Joint(s) in Any Extremity	

ADULT MEDICAL DISPOSITION

RFC Assessment Necessary (Physical and/or Mental)

ASSESSMENT OF POLICY ISSUES

SYMPTOMS EVALUATION

List the claimant's symptoms:

Pain Weakness

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?

Yes

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone?

No

When considering the following factors, which were the most informative in assessing the consistency of the individual's statements about their symptom related limitations with all the evidence in file?

ADLs Longitudinal treatment records

What is your assessment of the consistency of the individual's statements regarding symptoms considering the total medical and non-medical evidence in file?

Partially Consistent

Back to top 10 of 15: 1A: Disability Determination Explanation - DDE

Assessment of consistency regarding symptom related limitations: The evidence in file does not support the level of severity alleged and statements are felt to be partially consistent.

EVALUATING MEDICAL OPINIONS

There is no indication that there is a medical opinion from any medical source.

RESIDUAL FUNCTIONAL CAPACITY

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

RFC1

Indicate whether this Physical Residual Functional Capacity (RFC) assessment is for: Current Evaluation

Does the individual have exertional limitations? Yes

Rate the individual's exertional limitations:

Occasionally (occasionally is cumulatively 1/3 or less of an 8 hour day) lift and/or carry (including upward pulling): 20 pounds

Frequently (frequently is cumulatively more than 1/3 up to 2/3 of an 8 hour day) lift and/or carry (including upward pulling): 10 pounds

Stand and/or walk (with normal breaks) for a total of: About 6 hours in an 8-hour workday

Back to top 11 of 15: 1A: Disability Determination Explanation - DDE

Sit (with normal breaks) for a total of: About 6 hours in an 8-hour workday

Push and/or pull (including operation of hand and/or foot controls): Unlimited, other than shown, for lift and/or carry

Does the individual have postural limitations? Yes

Rate the individual's postural limitations: Climbing Ramps/stairs: Frequently Climbing Ladders/ropes/scaffolds: Frequently Balancing: Unlimited Stooping (i.e., bending at the waist): Unlimited Kneeling: Frequently Crouching (i.e., bending at the knees): Frequently Crawling: Frequently

Does the individual have manipulative limitations? No

Does the individual have visual limitations? No

Does the individual have communicative limitations? 12 of 15: 1A: Disability Determination Explanation - DDE

No

Does the individual have environmental limitations? No

RFC - Additional Explanation INITIAL: Claimant is 57 years old with allegations of past MVA, hip, neck and back pain, body numbness and insomnia. Claimant was in MVA in 2012. 2013 MRI - C-SPINE: R paracentral disc herniation C4-C5 w/R sided narrowing MRI - LUMBAR - R paracentral disc herniation L5-S1 9/2022 R HIP X-RAY: arthritis changes in R hip w/increased sclerosis decreased joint space 9/2022 EXAM: Sits in chair without distress; c/o pain improved by rest; ambulating without assistive devices; WT-69.85kg; BMI: 24.9; B/P-126/86; GAIT: WNL; Coordination: WNL; HIP EXAM: Flex-120; Adduction: 15; Extension-20; Abduction: 40; IR: 5/5; Strength: L/E: 5/5; Normal sensation bilaterally; Vasculature: 2+; DTR LE: Patellar 2+/2+; Achilles: 2+/2+; DX: Avascular Necrosis bone of R hip 1/2023 - C/O R hip pain; interested in surgery; exam intact distally; R Hip Flex to 90 degrees; no deformity or tenderness; R LE neurovascularly intact; 2+ DP pulse; DX: Osteoarthritis, R hip 4/2023 POST OP Visit - S/P R total hip arthroplasty on surgery of 2/8/23; not in PT; no longer taking anything for pain control; using cane; happy w/progress; stable gait; incision healed nicely; R LE NVI, 2+ DP pulse; +EHL/FHL/GSC/TA; Sensation intact to light touch; no calf pain; negative Homan's; did not need anything for pain ADL - lives w/family; takes care of children; some personal

care issues; prepares meals; does laundry, dishes, ironing; walks, drives, shops, pays bills, plays chess, watches TV and sports, reads, socializes

These findings complete the medical portion of the disability determination.

MC/PC Signature

Dr. Eleanor Vance (019) 04/28/2023

ASSESSMENT OF POLICY ISSUES - CONTINUED

RECONCILING MEDICAL OPINIONS

There is no indication that there is a medical opinion from any medical source.

Back to top

ASSESSMENT OF VOCATIONAL FACTORS

ASSESSMENT OF THE INDIVIDUAL'S ABILITY TO PERFORM PAST RELEVANT WORK

A finding about the capacity for PRW has not been made. However, this information is not material because all potentially applicable Medical-Vocational Guidelines would direct a finding of "not disabled" given the individual's age, education, and RFC. Therefore, the individual can adjust to other work.

Past Relevant Work: Past Relevant Work is expedited.

Additional Past Work Titles:

```
Job Title:    Car crusher
Start Date:   MAY 2019
End Date:     JUNE 2020
```

APPLICATION OF MEDICAL - VOCATIONAL RULES: Other Work

Past Relevant Work is expedited.

Is the individual limited to unskilled work because of the impairments? No

Based on the seven strength factors of the physical RFC (lifting/carrying, standing, walking, sitting, pushing, and pulling), the individual demonstrates the maximum sustained work capability for the following:

LIGHT

Indicate the rule used to direct a determination or as a framework.

202.14 - Cl App Adv Age HS Skilled-Semi No Trans

Select one of the following: 14 of 15: 1A: Disability Determination Explanation - DDE

Vocational Rule Directs

DETERMINATION

Based on the documented findings, select the determination: Not Disabled

Is there medical evidence of DAA? There is no evidence of any substance abuse disorder/DAA issue

DI Claim/279362993

Indicate which of the following Acquiescence Rulings are applicable None of the ARs considered apply to this claim

REGULATION BASIS CODE (RBC)

Regulation Basis Code:

N32-20CFR416.920(g)-CLAIMANT AGE 18 OR OLDER

PERSONALIZED DISABILITY EXPLANATION (PDE)

PDE Text:

SIGNATURES

MC/PC Signature

Dr. Eleanor Vance (019) 04/28/2023

Disability Adjudicator/Examiner Signature:

Back to top 15 of 15: 1A: Disability Determination Explanation - DDE

Back to top

1 of 1: 2A: National Benefit Agency Determination Transmittal - 777

NATIONAL BENEFITS AGENCY

DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION 2. NBA CODE 3. FILING DATE 4. SSN DDS ODO DRS DQB INTPSC SOF 7/14/22 456-12-7890 X ☐ ☐ ☐ ☐

BIC (if CDB or DWB CLAIM)

1. NAME AND ADDRESS OF CLAIMANT (include ZIP Code) 6. WE'S NAME (if CDB or DWB CLAIM) ARTHUR MILLER 789 OAK AVE CHICAGO, IL 60601-1001

2. TYPE CLAIM (Title II) DIB FZ DWB CDB-R CDB-D RD-R RD-D RD P-R P-D MQFE ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

3. TYPE CLAIM (Title XVI) DI DS DC BI BS BC AI AS X ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

4. DATE OF BIRTH 10. PRIOR ACTION 11. REMARKS 05/21/1965 PD ☐ PT ☐ Ref Agy 8/29/22

5. DISTRICT-BRANCH OFFICE ADDRESS (include Zip Code) DO-BO NATIONAL BENEFITS AGENCY CODE Suite 375 373 Metropolis, MI 48201

6. DO-BO REPRESENTATIVE 14. DATE 11A. Presumptive Disability ☐ 11B. Impairment ☐ JOHN SMITH 888-999-1234

DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

1. CLAIMANT DISABLED 16A. PRIMARY DIAGNOSIS 16B. SECONDARY DIAGNOSIS A. ☐ Disability Osteoarthrosis & Allied D Began isorders B. ☐ Disability BODY SYS. 01 None Established (Med.Evd Ceased CODE NO. 7150 .- Insuf.to Est. Diagnosis)

2. DIARY TYPE MO/YR. REASON CODE NO. 6490

3. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/(216)(i) 19. CLAIMANT NOT DISABLED

A. ☐ Not Disab. for Cash Bene. A. X Through Date of B. ☐ Through C. ☐ Before Age 22 Purp. Current Determination (CDB Only) B. ☐ Disab. for Cash Benefit OCC YRS. 0 ED YRS. 12 Purp. Beg.

1. VOCATIONAL BACKGROUND 21. VR ACTION SC IN SC OUT Prev Ref

2. REG-BASIS CODE 23. MED LIST NO. 24. MOB CODE 25. REVISED 25A. Initial Recon Recon DHU ALJ Hearing Appeals Council U.S. District Court N32 DET ☐ X ☐ ☐ ☐ ☐ ☐ ☐

3. LIST NO. A. B. C. D. E. F.

4. RATIONALE ☐ See Attached SSA-4268-U4/C4 X Check If Vocational 20214 Rule Met. Cite Rule

5. A. ☐ Period of Disability B. ☐ Disability Period C. ☐ Estab Beg AND D. ☐ Continues E. ☐ Term

6. LTR/PAR NO. 30. DISABILITY EXAMINER-DDS 31. DATE 32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE 33. DATE Sarah Johnson 4/28/23 See Form DDE Dated: 04/28/23

32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print, or Type) 32B. SPEC. CODE Dr. Eleanor Vance (019) 19

1. REMARKS MULTIPLE IMPAIRMENTS CER:N EOR:Y DAA: SNO:NO CONSIDERED

34A. COMBINED MULTIPLE NONSEVERE-SEVERE

34B. COMBIPLE MULTIPLE NONSEVERE-NONSEVERE

1. BASIS CODE 36. REV. DET. CODES 37. NBA REPRESENTATIVE NBA CODE 38. DATE

Form NBA-777-A1 (1/23) Previous editions may be used

Electronic Input: ☐ DECISION 987654 ☐ CASE CONTROL Case Number

Disability Determination Explanation

This Disability Determination Explanation is for the DI claim(s) at the Recon level.

Claimant Information

Claimant Information

Name: Arthur Miller SSN: 456-12-7890 Claimant Gender: Male Current Age: 57 years 8 months (Advanced Age) Date of Birth: 05/21/1965 Age at AOD: 57 years 1 month (Advanced Age) AOD: 07/01/2022 Special Indications: Representative

DI Claim Information

Initial Filing Date: 07/14/2022 Age at Initial Filing Date: 57 years 1 month (Advanced Age)

Allegations of Impairments

The individual filed for Recon claim for disability on 07/14/2022 due to the following illnesses, injuries, or conditions: hip pain, nerve pain neck area, insomnia, and spine impairment The individual alleges inability to function and/or work as of: 07/01/2022

Technical Issues

Prior Filings

Decision / Determination Date	Decision	Claim Level	Claim Type	Filing Type	Initial Filing Date	Protective Filing Date	AC Remand Date
10/01/2013	DE	Initial	DI	Electronic	06/18/2013		

Does the individual have prior filings? Yes Does Collateral Estoppel apply? No Has the individual worked since last completing a disability report? No Alleged Onset Date (AOD): 07/01/2022 Has the individual performed work after the Alleged Onset Date (AOD)? No Has any period(s) of work been determined to be an unsuccessful work attempt, or involved subsidies/special conditions, impairment-related work expenses, or other technical issue(s)? No Does the DDS need to correct the POD?

Yes POD Provided by FO: DI not specified Revised POD: 07/14/2022 Reason for correcting POD: Other Explanation of reason for correcting POD: PFD

Evidence of Record

2 of 8: 3A: Disability Determination Explanation - DDE

Evidence Received

DMA Received Date	Source	Doc Name	Case Level	Evidence Found
2023-08-11T16:20:45.000Z	STERLING HEALTH CLINIC	MER	Recon	Medical Evidence
2023-07-26T13:26:31.000Z	Arthur Miller	3373-Funct Rprt-Adult	Recon	Non-Medical Evidence
2023-04-26T13:51:09.000Z	METRO HEALTH & WELLNESS	MER	Initial	Medical Evidence
2023-04-19T15:04:22.000Z	METRO HEALTH & WELLNESS	MER	Initial	Medical Evidence
2023-03-08T17:05:46.000Z	CENTRAL PLAINS MEDICAL CENTER	MER	Initial	Medical Evidence
2023-02-22T22:27:07.000Z		5002 ROC	Initial	Non-Medical Evidence
2023-02-18T03:12:53.000Z	METRO HEALTH & WELLNESS CENTER	MER	Initial	Medical Evidence
2023-02-09T23:41:56.000Z		5002 ROC	Initial	Non-Medical Evidence
2023-02-09T22:55:16.000Z	METRO HEALTH & WELLNESS CENTER	MER	Initial	Medical Evidence
2023-02-09T21:05:49.000Z	Unity Care Clinic	HIT MER	Initial	No Records/ Not Patient
2023-02-07T00:04:57.000Z		5002 ROC	Initial	Non-Medical Evidence
2023-02-06T23:56:30.000Z		5002 ROC	Initial	Non-Medical Evidence
2023-02-06T13:04:58.000Z	Unity Care Clinic	HIT Response	Initial	No Records/ Not Patient

DMA Received Date	Source	Doc Name	Case Level	Evidence Found
2023-02-04T00:17:52.000Z	Unity Care Clinic	HIT Response	Initial	No Records/ Not Patient
2023-01-27T02:11:36.000Z		5002 ROC	Initial	No Records/ Not Patient
2023-01-26T18:51:25.000Z	WILLOW CREEK MEDICAL CENTER	MER	Initial	Medical Evidence
2023-01-19T01:10:51.000Z	METRO HEALTH & WELLNESS CENTER	MER	Initial	No Records/ Not Patient
2022-12-28T22:57:57.000Z		5002 ROC	Initial	No Records/ Not Patient
2022-12-14T02:29:06.000Z		5002 ROC	Initial	No Records/ Not Patient
2022-12-09T22:06:53.000Z		3373-Funct Rprt-Adult	Initial	Non-Medical Evidence
2022-08-15T14:52:32.000Z		3369-Work Hx	Initial	Non-Medical Evidence
2013-09-28T09:53:35.000Z	WELLNESS CONSULTANTS LTD	MER	Copied	Medical Evidence

Case Notes

Case Notes

Last Updated Author Category Subject Note

Medical Advisor 416 Evaluation

No Medical Advisor 416 Evaluations have been associated with this claim.

Findings of Fact and Analysis of Evidence

Back to top 3 of 8: 3A: Disability Determination Explanation - DDE

Analysis RECONSIDERATION Denial: 04/28/2023 +++++ Y: DR. Elara Vance "No MDMI" +++++ P: DR. Eleanor Vance "Light" AGE: 51 PRIOR FILINGS: Yes ALLEGATIONS: hip pain, nerve pain neck area, insomnia, and spine impairment

EDUCATION: 12th PFD: 07/14/2022 DI: T-16 FORMS ========ADL======== 07/26/2023 CLMT ADL'S - Ability to work is limited due to inability to stand for prolonged periods, unable to lift objects overhead. Daily routine: arise from bed, personal hygiene, eat breakfast, minor home maintenance, local news, stream entertainment, dinner, bed. Does not care for anyone, no pets. Personal care: takes longer to dress due to inability to lift overhead. No special reminders for personal needs, grooming or meds. Simple meals. Is able to do laundry, dusting, dishwashing, vacuuming. Drives alone, shops in stores, handles finances. Hobbies: tv, listening to music, video gaming, solving puzzles, chess. Social activities: in person, on the phone, texting, mail. RT handed. How well do you handle stress "minimally", changes in routine "minimally". Wears glasses. 12/09/2022 ADL - lives w/family; takes care of children; some personal care issues; prepares meals; does laundry, dishes, ironing; walks, drives, shops, pays bills, plays chess, watches TV and sports, reads, socializes. Does not care for anyone, no pets. RT handed. How well do you handle stress "Minimally", changes in routine "Minimally". ========MENTAL CONDITIONS======== The claimant does not allege any psychiatric impairments, there is no reported treatment or prescriptions for any emotional issues. The claimant indicates that they handle stress "Minimally", changes in routine "Minimally". ========PHYSICAL CONDITIONS======== 07/06/2023 Sterling Health Clinic - CC lump in nipple, mild tenderness. PE: Neck L post neck mild tenderness on palpation of C spine area approx at C7 area. A/P HTN, lump in the RT breast, C- spine pain, thyroid abnormality. 4/13/2023 Metro Health & Wellness Center - POST OP Visit - S/P R total hip arthroplasty on surgery of 2/8/23; not in PT; no longer taking anything for pain control; using cane; happy w/progress; stable gait; incision healed nicely; HIP ROM improving; R LE NVI, 2+ DP pulse; +EHL/FHL/GSC/TA; Sensation intact to light touch; no calf pain; negative Homan's; did not need anything for pain 02/08/2023 Central Plains Medical Center - Would like to proceed with robotic assisted total hip arthroplasty. A/P osteoarthritis of RT hip. X-rays RT hip arthroplasty with prothesis in good position and alignment. Left hip: SI joints and symphysis pubis are unremarkable.

Operative report: RT total hip arthroplasty.

Discharge summary: s/p RT total hip arthroplasty.

1/26/2023 Metro Health & Wellness Center - C/O R hip pain; interested in surgery; exam intact distally; R Hip Flex to 90 degrees; no deformity or tenderness; R LE neurovascularly intact; 2+ DP pulse; DX: Osteoarthritis RT hip 01/20/2023 Dr. Emily Carter, MD - ECHO: LVEF 55% 9/15/2022 Metro Health & Wellness Center - EXAM: Sits in chair without distress; c/o pain improved by rest; ambulating without assistive devices; WT-69.85kg; BMI: 24.9; B/P-126/86; GAIT: WNL; Coordination:

WNL; HIP EXAM: Flex-120; Adduction: 15; Extension-20; Abduction: 40; IR: 5/5; Strength: L/E: 5/5; Normal sensation bilaterally; Vasculature: 2+; DTR LE: Patellar 2+/2+; Achilles: 2+/2+; DX: Avascular Necrosis bone of R hip 9/15/2022 Metro Health & Wellness Center - R HIP X-RAY: arthritis changes in R hip w/increased 4 of 8: 3A: Disability Determination Explanation - DDE

sclerosis decreased joint space 03/15/2013 WELLNESS CONSULTANTS LTD - MRI RT shoulder: Large complex-partial-thickness tear with a- superimposed small full-thickness tear of the distal rotator cuff tendon. Regional abnormal bone marrow signal in the superolateral humeral head may reflect contusion at the attachment of the distal rotator cuff tendon at the tuberosity. Grade 2 SLAP tear of the glenoid labrum anteriorly. 03/15 2013 WELLNESS CONSULTANTS LTD - MRI C-SPINE: R paracentral disc herniation C4-C5 w/R sided narrowing. MRI: LUMBAR - R paracentral disc herniation L5-S1

416 - Medical Evaluation

No 416-Medical Evaluations have been associated with this claim.

Adult Medically Determinable Impairments (MDI) and Severity

Does the individual have one or more medically determinable impairments? Yes

Adult Medically Determinable Impairments (MDI)

Body System	Impairment Diagnosis	Priority	Severity
01 - Musculoskeletal system	7150 - Osteoarthrosis and Allied Disorders	Primary	Severe
20 - Special/other	2480 - Diagnosis Established--No Predetermined List Code of Medical Nature Applicable	Secondary	Severe
01 - Musculoskeletal system	7240 - Disorders of the Skeletal Spine	Other	Severe

PRT1 - Psychiatric Review Technique (PRT) (1 of 1)

Evaluation Period: Current Evaluation Subject: Mental - No MDMI There are no mental medically determinable impairments established.

PRT Additional Explanation: Additional Explanation: The MER does not document the presence of a discreet mental impairment.

These findings complete the medical portion of the disability determination. MC/PC Signature: Christopher Thorne PhD Medical Specialty Code: 38 Psychology Date Signed: 08/25/2023

Adult Listings Considered

Listing	Description	Subsection	PRT Assessment
1.18	Abnormality of a Major Joint(s) in Any Extremity		

Adult Medical Disposition

RFC Assessment Necessary

Back to top 5 of 8: 3A: Disability Determination Explanation - DDE

Assessment of Policy Issues

Symptoms Evaluation

Claimant's Symptoms

- Pain
- Weakness

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms? Yes

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone? No

What is your assessment of the consistency of the individual's statements regarding symptoms considering the total medical and non-medical evidence in file? Partially consistent

Explain the assessment of consistency regarding symptom related limitations.

Consistency Statement Physical:

Careful consideration has been given to the claimant's statements regarding the alleged symptoms and their effect on functioning. The claimant diagnosed with HTN, dysfunction of major joint, and spine disorder. The claimant's impairments could reasonably be expected to produce some symptoms, but their intensity and the effect on functioning are not consistent with the total evidence in file. The claimant states in his ADL' that his ability to work is limited due to the inability to stand for prolonged periods of time, unable to lift objects, is able to prepare simple meals, do laundry, dusting, dishes, vacuuming, drives alone, shops in stores and handles finances. Based on a review of the objective and functional evidence, the individual's statements are found to be partially consistent.

Evaluate and Reconcile Medical Opinions

There is no indication that there is a medical opinion from any medical source.

Residual Functional Capacity

RFC1 - Physical Residual Functional Capacity (1 of 1)

Evaluation Period: Current Evaluation

Does the individual have exertional limitations? Yes

Occasionally lift and/or carry (including upward pulling): 20 pounds Frequently lift and/or carry (including upward pulling): 10 pounds

Exertional Limitation	Rating
Push and/or pull in upper extremities	Unlimited, other than lift and/or carry
Push and/or pull in lower extremities	Unlimited, other than lift and/or carry

Stand and/or walk (with normal breaks) for a total of: About 6 hours in an 8 hour workday Sit (with normal breaks) for a total of: About 6 hours in an 8 hour workday

Does the individual have postural limitations? Yes

Back to top

6 of 8: 3A: Disability Determination Explanation - DDE

Postural Limitation	Rating
Climbing ramps / stairs	Frequently
Climbing ladders / ropes / scaffolds	Frequently
Balancing	Unlimited
Stooping (i.e., bending at the waist)	Unlimited
Kneeling	Frequently
Crouching (i.e., bending at the knees)	Frequently
Crawling	Frequently

Does the individual have manipulative limitations? No Does the individual have visual limitations? No Does the individual have communicative limitations? No Does the individual have environmental limitations? No

RFC Additional Explanation

Allegation: hip pain, nerve pain neck area, insomnia, and spine impairment. Claimant is 58 years old with allegations of past MVA, hip, neck and back pain, body numbness and insomnia. Claimant was in MVA in 2012. 2013 MRI - C-SPINE: R paracentral disc herniation C4-C5 w/R sided narrowing MRI - LUMBAR - R paracentral disc herniation L5-S1 9/2022 R HIP X-RAY: arthritis changes in R hip w/increased sclerosis decreased joint space 9/2022 EXAM: Sits in chair without distress; c/o pain improved by rest; ambulating without assistive devices; WT-69.85kg; BMI: 24.9; B/P-126/86; GAIT: WNL; Coordination: WNL; HIP EXAM: Flex-120; Adduction: 15; Extension-20; Abduction: 40; IR: 5/5; Strength: L/E: 5/5; Normal sensation bilaterally; Vasculature: 2+; DTR LE: Patellar 2+/2+; Achilles: 2+/2+; DX: Avascular Necrosis bone of R hip 1/2023 - C/O R hip pain; interested in surgery; exam intact distally; R Hip Flex to 90 degrees; no deformity or tenderness; R LE neurovascularly intact; 2+ DP pulse; DX: Osteoarthritis, R hip 4/2023 POST OP Visit - S/P R total hip arthroplasty on surgery of 2/8/23; not in PT; no longer taking anything for pain control; using cane; happy w/progress; stable gait; incision healed nicely; HIP ROM improving; R LE NVI, 2+ DP pulse; +EHL/FHL/GSC/TA; Sensation intact to light touch; no calf pain; negative Homan's; did

not need anything for pain. RECON: 07/06/2023 Sterling Health Clinic - CC lump in nipple, mild tenderness. PE: Neck L post neck mild tenderness on palpation of C spine area approx at C7 area. A/P HTN, lump in the RT breast, C-spine pain, thyroid abnormality. 07/26/2023 CLMT ADL'S - Ability to work is limited due to inability to stand for prolonged periods, unable to lift objects overhead. Daily routine: arise from bed, personal hygiene, eat breakfast, minor home maintenance, local news, stream entertainment, dinner, bed. Does not care for anyone, no pets. Personal care: takes longer to dress due to inability to lift overhead. No special reminders for personal needs, grooming or meds. Simple meals. Is able to do laundry, dusting, dishwashing, vacuuming. Drives alone, shops in stores, handles finances. No new and material MER to change RFCA, stays the same.

These findings complete the medical portion of the disability determination.

MC/PC Signature: Anya Sharma MD Medical Specialty Code: 19 Internal Medicine Date Signed: 08/23/2023

Mental Residual Functional Capacity

No MRFCs are associated with this claim.

Assessment of Vocational Factors - Individual's Ability to Perform Past Relevant Work

Expedited Vocational Assessment (EVA)

7 of 8: 3A: Disability Determination Explanation - DDE

A finding about the capacity for PRW has not been made. However, this information is not material because all potentially applicable Medical-Vocational Guidelines would direct a finding of "not disabled" given the individual's age, education, and RFC. Therefore, the individual can adjust to other work.

All Past Work

Relevant	Job Title	Start Date	End Date	DOT Information	SVP Strength
Not Yet Answered	Car crusher	MAY 2019	JUNE 2020		

Relevant	Job Title	Start Date	End Date	DOT Information	SVP Strength

Description: --

Application of Medical-Vocational Rules: Other Work

Is the individual limited to unskilled work because of the impairments? No Based on the seven strength factors of the physical RFC (lifting/carrying, standing, walking, sitting, pushing, and pulling), the individual demonstrates the maximum sustained work capability of the following: Light

The highest grade of school completed by the individual is: 12th Grade Indicate the rule used to direct a determination or as a framework. Select how the rule is applied 202.13 - Light | Approaching Advanced (50-54) | HS or more | Unskilled/ None Rule used as a Framework

Select documentation method: Cite SSR

Cite the appropriate Social Security Ruling (SSR) 83-14: Other work with combined impairments

Vocational Analysis

Vocational Case Notes

Last Updated	Author	Category	Subject	Note

Determination

Determination for the DI claim(s) at the Recon Level

Based on the documented findings, select the determination: Not Disabled

Is there medical evidence of DAA? There is no evidence of any substance abuse disorder/DAA issue.

DI Claim / 987654321

Indicate which of the following Acquiescence Rulings are applicable: None of the ARs considered apply to this claim Regulation Basis Code: N32-20CFR416.920(g) CLAIMANT AGE 18 OR OLDER

Signatures

Adult Overall Medical Disposition Signature

MC/PC Signature: Anya Sharma MD Medical Specialty Code: 19 Internal Medicine Date Signed: 08/23/2023

Disability Examiner Signature

Back to top 8 of 8: 3A: Disability Determination Explanation - DDE

This reconsideration file has been thoroughly reviewed to ensure that the total evidence of record is sufficient and consistent to support the proposed determination.

Disability Examiner Signature: David Peterson Date Signed: 08/26/2023

Back to top

Form SSA-831 (02-2017) UF Discontinue Prior Editions National Benefits Agency

DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION				
DDS [ ] ODO [ ] DPB [ ] DQB [ ] OIO [ ]	**2. DDS CODE** **V24**	**3. FILING DATE** **07/14/2022**	**4. SSN** **456-12-7890**	**BIC** **CDB** **DWB** **CLA**
5. NAME AND ADDRESS OF CLAIMANT (*include ZIP Code*) Arthur Miller 789 Oak Ave Chicago, IL 60601	6. WE'S NAME (*IF CDB OR DWB CLAIM*)			
7. TYPE CLAIM (Title II) DIB [ ] FZ [ ] DWB [ ] CDB-R [ ] CDB-D [ ] RD-R [ ] RD [ ] P-R [ ] P-D [ ] MQFE [ ]				
8. TYPE CLAIM (Title XVI) DI [ ] DS [ ] DC [ ] BI [ ] BS [ ] BC [ ]				
9. DATE OF BIRTH 05/21/1965	10. PRIOR ACTION PD [ ] PT [ ]	11A. [ ] Presumptive Disability _____	11B. [ ] Impairment _____	
11. REMARKS AOD: 07/01/2022,	12. DISTRICT-BRANCH OFFICE ADDRESS (*include*	DO-BO CODE 012		

1. DESTINATION				**BIC**
DDS [ ] ODO [ ] DPB [ ] DQB [ ] OIO [ ]	**2. DDS CODE V24**	**3. FILING DATE 07/14/2022**	**4. SSN 456-12-7890**	**CDI DW CLA**

Receipt Date: 05/18/2023 Recon Requested: 05/12/2023	*ZIP Code*) NATIONAL BENEFITS AGENCY Suite 100, 450 Riverfront Ave Metropolis, MI 48201	
	13. DO-BO REPRESENTATIVE Arthur Pendragon (888) 999-1234	14. DATE

DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

15. CLAIMANT DISABLED	**16A. PRIMARY DIAGNOSIS**	**BODY SYS.**	**CODE NO.**	**16B. SECONDARY DIAGNOSIS**	**CODE NO.**
A. [ ] Disability Began _____ B. [ ] Disability Ceased	Osteoarthrosis and Allied Disorders	01	7150	Diagnosis Established--No Predetermined List Code of Medical Nature Applicable	2480
17. DIARY TYPE	MO./YR.	REASON			

18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/(216)(i)

A. [ ] Not Disab. for Cash Bene. Purp.
B. [ ] Disab. for Cash Benefit Purp. Beg.

19. CLAIMANT NOT DISABLED

A. [ ] Through Date of Current Determination

18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/(216)(i)	**19. CLAIMANT NOT DISABLED** B. [ ] Through _____ C. [ ] Before Age 22 (CDB only)

20. VOCATIONAL BACKGROUND	**OCC YRS.**	**ED YRS.**	**21. VR ACTION**	**SC IN**	**SC OUT**	**Prev Ref**
		12		A. [ ]	B. [ ]	C. [ ]

22. REG-BASIS CODE	**23. MED LIST NO.**	**24. MOB CODE**	**25. REVISED DET [ ]**	**25A. Initial A. [ ]**	**Recon B. [ ]**	**Recon DHU C. [ ]**
P45						

26. LIST NO.	A. _____	B. _____	C. _____	D. _____	E. _____	F. _____

27. RATIONALE	**[ ] See Attached SSA-4268**	**[ ] Vocational Rule Met**			
28.	A. [ ] Period of Disability	B. [ ] Disability Period	C. [ ] Estab Beg	AND D. [ ] Continues	E. [ ] Term

29. LTR/ PAR NO.	**30. DISABILITY EXAMINER-DDS** **David Miller**	**31. DATE 08/26/2023**	**32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE** **RFC1 in DDE 08/23/2023**	**33. DATE 08/23/2023**	
34. REMARKS	32A. PHYSICIAN OR MEDICAL SPEC. NAME (*Stamp, Print or Type*) Anya Sharma MD	32B. SPEC. CODE 25	MULTIPLE IMPAIRMENTS CONSIDERED 34A. COMBINED MULTIPLE NONSEVERE-SEVERE 34B. COMBINED MULTIPLE NONSEVERE-NONSEVERE		
	35. BASIS CODE	36. REV. DET. CODES	37. SSA REPRESENTATIVE	SSA CODE	38. DATE

Electronic Input: [ ] DECISION [ ] CASE CONTROL

Claimant's Social Security Number Appointed Representative's Rep ID 456-12-7890 ZQA9W8ERTG

Claimant's Appointment of a Representative

Section 1 - Claimant's Information

Social Security Number 456-12-7890

First Name	Initial	Last Name
Arthur		Miller

Mailing Address 789 Oak Ave

City	State	ZIP/Postal Code	Country – if outside the U.S.
Chicago	IL	60601-1001	

Phone Number	Alternate Phone Number (Optional)
(773) 555-9876	

Country/Area Code	Phone Number	Country/Area Code	Phone Number

---

Number Holder's Information (Complete when applicable)

My claim is based on another person's work or earnings (e.g., spouse or parent). This person's information is different from mine.

Number Holder's Social Security Number

First Name	Initial	Last Name

Section 2 - Disclosure (Claimant Only)

☒ By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. (The appointed representative's partners, associates, delegates and designees must be prepared to provide information in order to be authenticated.)

Section 3 - Principal Representative (Claimant only – Complete when applicable)

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name 2 of 4: 1B: NBA-1696 - Client's Appointment of a Representative - 1696 03:41:45 p.m. 07-28-2022 3/7 1234567 Fax Page 4 of 6

Form NBA-1696 (09-2019) UF	**Client's Account Number**	**Appointed Representative's Rep ID**
	456-12-7890	ZQA9W8ERTG

Section 4 - Representative's Information (Client and Representative) Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.nationalbenefitsagency.gov/rep, contact us at 1-800-555-0100 (TTY 1-800-555-0101), or visit your local National Benefits Agency office.

Representative's Rep ID ZQA9W8ERTG

First Name	**Initial**	**Last Name**
Eleanor	R.	Walker

Mailing Address 1789 Main Street, Suite 201

City	**State**	**ZIP/Postal Code**	**Country – if outside the U.S.**
Anytown	CA	90210	

Phone Number	Alternate Phone Number (Optional)		
(310) 555-0189			
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Section 5 - Representative's Status, Affiliations, and Certifications (Representative Only) Representative's Status Part A - Type of Representative (Representatives have a duty to keep their information current)

[x] I am an attorney (NBA regulation states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)

[ ] I am a non-attorney eligible for direct payment (NBA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.nationalbenefitsagency.gov/rep for criteria).

[ ] I am a non-attorney not eligible for direct payment.

Representative's Status Part B – Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law. [ ] Yes [x] No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. [ ] Yes [x] No

Back to top 3 of 4: 1B: SSA-1696 - Claimant's Appointment of a Representative - 1696

1234567 Fax 03:42:16 p.m. 07-28-2022 4/7

Form SSA-1696 (09-2019) UF Page 5 of 6 Claimant's Social Security Number Appointed Representative's Rep ID

456-12-7890 ZQA9W8ERTG

Section 5 - Continued (Representative Only)

Affiliation Information

If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer's tax identification number. (Do not complete this section if you do not qualify for direct payment.)

EIN 88-7776655

Organization's Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim) Legal Advocates for the Disabled, Walker, Thompson & Peterson, P.C.

Representative's Business Address (if different than mailing address)

City State ZIP/Postal Code

Country - if outside the U.S.

Representative's Certification

I accept this appointment and certify the following:

I understand and agree that I will comply with SSA's laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies. I understand that if I fail to comply with any of SSA's laws and rules I may be suspended or disqualified as a representative before SSA. I will not disclose any information to any unauthorized party without the claimant's specific written consent. I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration. I am not disqualified from representing the claimant as a current or former officer or employee of the United States. I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form. I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original. I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -

I have registered for and obtained a Rep ID, and my registration information is up-to-date. I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE (Representative's

Back to top 4 of 4: 1B: NBA-1696 - Claimant's Appointment of a Representative - 1696 03:42:54 p.m. 07-28-2022 1234567 Fax 5/7

Form NBA-1696 (09-2019) UF	**Claimant's Identification Number**	**Appointed Representative's Rep ID**	**Page 6 of 6**
	456-12-7890	ZQA9W8ERTG	

Section 6 - Claim Type (Claimant or Representative)

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title 2 (RSDI), Title 16 (SSI), Title 18 (Medicare Coverage), and Title 8 (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (Check all that apply)

- [x] Claim/Appeal for Title 2 Disability Benefits
- [x] Claim/Appeal for Title 16
- [x] Concurrent Title 2 and Title 16
- [ ] Claim/Appeal for Retirement Benefits
- [ ] Claim/Appeal for Title 18 (Medicare), 8 (Special Veteran's Benefits)
- [ ] Continuing Disability Review (CDR)
- [ ] Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement (Representative Only)

Check one box below:

- [x] I will request a fee and direct payment of this fee. Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. (We must authorize the fee.)
- [ ] I will request a fee but not direct payment. Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. (We must authorize the fee.)
- [ ] I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual. Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. (We do not need to authorize the fee if all regulatory conditions apply.)
- [ ] I waive the right to a fee.

Section 8 - Signatures (Claimant and Representative)

Representative's Signature	**Signature 1**	**Date 7-14-22**
Claimant's Signature	Signature 2	Date 7-14.22

NATIONAL BENEFITS AGENCY FEE AGREEMENT

I, Arthur Miller SSN: 456-12-7890, hereby hire Walker, Thompson & Peterson, P.C. (The Firm), Attorneys at Law, 1789 Main Street, Suite 201, Anytown, CA 90210 to represent me in my claim(s) for National Benefits Agency Disability and/or Supplemental Assistance Income (SAI) benefits. I designate Eleanor R. Walker as my primary representative and I give my consent to Eleanor R. Walker to designate another attorney within The Firm to act as my co-representative before the National Benefits Agency (NBA) without further notice. This agreement shall apply to all stages of the application and appeals process with the NBA.

There is no fee unless I receive a favorable or partially favorable decision for my claim. The firm has not promised that my case will result in a favorable decision. In consideration of the representation, I agree to have NBA pay the Firm the lesser of (a) 25% of any past due benefits awarded to me and my family or (b) $6,000 (or such higher limit set by the Commissioner of the NBA pursuant to 206 (a)(2)(A)). I understand that NBA must approve any fee charged by my attorney for services provided in proceedings before the NBA. Claimant also understands and agrees that NBA will withhold the attorney fees from the payment of past due benefits, and NBA will pay such fees directly to the attorney. Under the National Benefits Agency Regulations, "past due benefits" include all benefits payable to claimants and/or their families/dependents.

If the claimant is awarded benefits by the Appeals Division or by a Federal Court, or following an Order of Remand issued by the Appeals Division or Federal Court, the fee shall be 25% of the total past due benefits to the Claimant and/or the Claimant's family. If a favorable decision is obtained at the Appeals Division or Federal Court level, the Attorney will file a fee petition with NBA, requesting Attorney's fees be approved. If NBA does not approve this fee agreement, Attorney will submit a Fee Petition to the National Benefits Agency for approval of a reasonable fee in accordance with the applicable regulations.

I agree to pay all expenses in connection with my case, or pay the attorney's law firm back for any such expenses they pay. These expenses include but may not be limited to expenses charged by others, such as for medical reports or special medical/vocational examinations.

Signed: X_ Dated: _ Arthur K. Miller 7-14-22

Accepted and Agreed to by WALKER, THOMPSON & PETERSON, P.C.

Eleanor R. Walker Thomas L. Thompson Robert M. Peterson

Michael J. Walker Christopher S. Andrews James P. Davis

Sarah J. White William R. Harris

Revised 09/21/21

1 of 6: 3B: T16 Notice of Disapproved Claim - L444

NATIONAL BENEFITS AGENCY
SUPPLEMENTAL SECURITY INCOME
Notice of Disapproved Claims

Arthur Miller 789 Oak Ave Chicago, IL 60601-1001 Telephone: (888) 999-1234 Date: April 28, 2023 Claim Number: 456-12-7890

We are writing about your claim for Supplemental Security Income (SSI) payments. Based on a review of your health problems you do not qualify for benefits on this claim. This is because you are not disabled or blind under our rules.

The Decision on Your Case

The following report(s) were used to decide your claim:

METRO HEALTH & WELLNESS report received 04/26/2023 & 04/19/2023 CENTRAL PLAINS MEDICAL CENTER report received 03/08/2023 METRO HEALTH & WELLNESS report received 02/09/2023 Willow Creek Medical Center report received 01/26/2023 WELLNESS CONSULTANTS LTD report received 09/28/2013

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

You said you are unable to work because of:

CAR ACCIDENT INJURIES; INSOMNIA; BODY NUMBNESS; HIP, NECK, BACK PROBLEMS; LEARNING DISABILITY

NFM-103-1 NFM 101 (12/10) (SSA-L444)

Back to top 2 of 6: 3B: T16 Notice of Disapproved Claim - L444 Page 2

The evidence shows while the medical conditions may pose some restrictions, they do not limit all daily activities to prevent you from working.

If your condition gets worse and keeps you from working write, call or visit any Social Security office about filing another application.

About the Decision

Doctors and other trained staff looked at this case and made these decisions. They work for the state but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in this case.

The Disability Rules

You must meet certain rules to qualify for SSI payments based on disability. Your health problems must:

keep you from doing any kind of substantial work (described below), and last, or be expected to last, for at least 12 months in a row, or result in death.

Information About Substantial Work

Generally, substantial work is physical or mental work a person is paid to do. Work can be substantial even if it is part-time. To decide if a person's work is substantial, we consider the nature of the job duties, the skills and experience needed to do the job, and how much the person actually earns.

Usually, we find that work is substantial if gross earnings average over $1470 per month after we deduct allowable amounts. This monthly amount is higher for Social Security disability benefits due to blindness.

A person's work may be different than before his/her health problems began. It may not be as hard to do and the pay may be less. However, we may still find that the work is substantial under our rules.

If a person is self-employed, we consider the kind and value of his/her work, including his/her part in the management of the business, as well as income, to decide if the work is substantial.

Information About National Benefits Agency Benefits

The application you filed for SSI was also a claim for National Benefits Agency benefits. We looked into whether you qualify for National Benefits Agency and found that you do not. If you disagree with this decision, you have the right to appeal.

Information About Medicaid And Other Benefits

You may want to contact your local public assistance office to find out if you qualify for payments from them.

If You Disagree With The Decision

If you disagree with this decision, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case.

You have 60 days to ask for an appeal. The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period. You must have good reason for waiting more than 60 days to ask for an appeal. You have to ask for an appeal in writing. We will ask you to sign a form NBA-561-U2, called "Request for Reconsideration." You may contact one of our offices or call 1-800-555-0100 to request this form. Or you may complete

this form online at http://www.nationalbenefitsagency.gov/disability/appeal. Contact one of our offices if you want help.

In addition, you should complete a "Disability Report - Appeal" to tell us about your medical condition since you filed your claim. You may contact one of our offices or call 1-800-555-0100 to request this form. Or, you may complete this report online after you complete the online Request for Reconsideration.

How the Appeal Works

You have the right to review the facts in your case. You can give us more facts to add to your file. Then we will decide your case again. You will not meet the person who will decide your case.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing, you might lose some benefits, or not qualify for any benefits. So, if you disagree with this decision, you should ask for an appeal within 60 days.

If You Want Help With Your Appeal

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local National Benefits Agency office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

If You Have Any Questions

If you have any questions, you may call us toll-free at 1-800-555-0100, or call your local National Benefits Agency office at (888) 999-1234. We can answer most questions over the phone. You can also write or visit any National Benefits Agency office. The office that serves your area is located at:

(NBA-F999) NFM-103-1 NFM 103 (12/10)


```
NATIONAL BENEFITS AGENCY
Suite 100
450 Riverfront Ave
Metropolis, MI 48201
```

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Suspect National Benefits Agency Fraud?

If you suspect National Benefits Agency fraud, please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at 1-800-999-3000 (TTY 1-866-999-3001).

National Benefits Agency

c: ELEANOR ROSE WALKER 1789 Main Street Suite 201 Anytown, CA 90210

STOLOS

NFM-103-1 NFM 103 (12/10) (SSA-L444)

Back to top 6 of 6: 3B: T16 Notice of Disapproved Claim - F123

NATIONAL BENEFITS AGENCY TEXOMA Records Processing Unit Floor 3

Texoma, TX 75001-1234

April 28, 2023

ELEANOR ROSE WALKER 1789 MAIN STREET SUITE 201 ANYTOWN CA 90210

NAME: ARTHUR MILLER SSN: 456-12-7890 CASE NUMBER: 987654

We are forwarding you a copy of the correspondence sent to your client in connection
with their claim for disability benefits under the National Benefits Act. Please advise your
client to read the entire letter and respond appropriately.

A. Reynolds, Benefits Specialist

Back to top (NBA-F123)

1 of 1: 4B: Informal Request for Reconsideration - INFRECON

I561 SUMMARY 456-12-7890 MAY 12, 2023

You have successfully submitted your Disability Appeal on May 12, 2023 at 8:35:05 AM Eastern time.

Summary Review

Information about Eleanor R. Walker Relationship: Appointed Representative (Attorney) or Staff Mailing Address: 1789 Main Street, Suite 201, Anytown, CA, 90210 Phone: (310) 555-0189 Fax Phone: (310) 555-0190

Information about Arthur Miller Name: Arthur Miller Mailing Address: 789 Oak Ave, Chicago, Illinois, 60601 Does Arthur Miller live at the above address?: Yes Daytime Phone Number: (773) 555-9876 Alternative Phone Number: Email Address: arthur.miller.claim@fakemail.net

Request for Reconsideration Date Notice of Decision received: 04/28/2023 Claim Number: Reason for Appeal: The decision does not conform to the evidence.

1 of 4: 5B: T16 Disability Reconsideration Notice - L1130

ARTHUR MILLER 789 Oak Ave Chicago, IL 60601-1001

CONFIDENTIALITY NOTICE: The accompanying material contains sensitive information. This information may be privileged and confidential, and intended for the use of the recipient named in this correspondence. If you have received this information in error, please contact us immediately. Back to top National Benefits Agency Supplemental Security Income Important Information

Date: 08/30/2023 Claim Number: 9876543

ARTHUR MILLER 789 OAK AVE CHICAGO IL 60601-1001

Upon receipt of your request for reconsideration we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your case has been thoroughly evaluated; this includes the medical evidence and the additional information received since the original decision. We find that the previous determination was proper under the law. Attached to this notice is an explanation of the decision we made in your claim and how we arrived at it.

The Decision

See the enclosed Explanation.

If You Disagree With The Decision

If you do not agree with this decision, you have the right to request a hearing. A person who has not seen your case before will look at it. That person is an Administrative Law Judge (ALJ). The ALJ will review the parts of the decision that you think are wrong and correct any mistakes. The ALJ may also review the parts of our decision that you think are right. We will make a decision that may or may not be in your favor.

You have 60 days to ask for a hearing. The 60 days start the day you receive this letter. We assume you received this letter 5 days after the date on it unless you show us that you did not receive it within the 5-day period. You must have a good reason for waiting more than 60 days to ask for a hearing. You must ask for a hearing in writing. Please use our "Request for Hearing" form, HA-501, available at https://www.nationalbenefitsagency.gov/forms/online. Or, you can complete your appeal online at www.nationalbenefitsagency.gov/disability/appeal. You can also contact us to request the form or if you need help filling it out. In addition,

you should complete form NBA-3441 "Disability Report – Appeal" to tell us about your medical condition since filing the claim. You can go to our website at https://www.nationalbenefitsagency.gov/forms to locate this form. If you complete your appeal request online, you will be able to complete and submit this form with your appeal request. Please read the enclosed pamphlet, "Your Right to an Administrative Law Judge Hearing and Appeals Council Review of Your National Benefits Agency Case". It contains more information about the hearing.

How The Hearing Process Works

After we send your case for a hearing, an Administrative Law Judge (ALJ) will mail you a letter at least 75 days before the hearing to tell you its date, time, and place. The letter will explain the law in your case and tell you what has to be decided. Since the ALJ will review all the facts in your case, it is important that you give us any new facts as soon as you can.

The hearing is your chance to tell the ALJ why you disagree with the decisions in your case. You can give the ALJ new evidence and bring people to testify for you. The ALJ also can require people to bring important papers to your hearing and give facts about your case. You can question these people at your hearing.

If You Want Help With Your Appeal

You may choose to have a representative help you with your case. We will work with this person just as we would work with you. If you decide to have a representative, you should find one quickly so that person can start preparing your case.

9876543/Processed XYZ9 LMN0/QRPS//12345678 Form NBA-L1130 (07-2017) UF 3 of 4: 5B: T16 Disability Reconsideration Notice - L9876

Many representatives charge a fee only if you win your case. Others may represent you for free. Generally, your representative cannot charge a fee unless we approve it. Your local National Benefits Agency office can give you a list of groups that can help you find a representative.

If you get a representative, you or that person must notify us in writing. You can go to https://secure.nba.gov/nba9876/front-end to complete the form with your representative online, download the form NBA-9876 "Claimant's Appointment of Representative" at www.nationalbenefitsagency.gov/forms, or contact us to request a form.

You can also log into your my National Benefits Agency account for information and online service options regarding your representation.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with the decision and you file a new application instead of an appeal:

You might lose some benefits or not qualify for any benefits and We could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision, you should file an appeal.

Suspect National Benefits Agency Fraud?

Please visit https://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at (800) 999-3000. If you are deaf or hard of hearing, call TTY (800) 999-3001.

Need More Help?

1. Visit www.nationalbenefitsagency.gov for fast, simple, and secure online service.
2. Call us at 1-800-555-0100, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-555-0101. Please mention this letter when you call.
3. You may also call your local office at (888) 999-1234.

METROPOLIS FIELD OFFICE
NATIONAL BENEFITS AGENCY
SUITE 100
450 RIVERFRONT AVE
METROPOLIS MI 48201

How are we doing? Go to www.nationalbenefitsagency.gov/feedback to tell us.

National Benefits Agency

CC: Eleanor R. Walker; WALKER ASSOCIATES PC

Enclosure(s):
Explanation
NBA Pub. No. 80-20593 (Your Right To An Appeals Division Hearing And Review Of Your National Benefits Agency Case)

9876543/Processed XY2 AZ3/MVC // 12345678 Form NBA-L9876 (05-2023) XYZ

Back to top 4 of 4: 5B: T16 Disability Reconsideration Notice - L1130

Explanation

We used the following medical and non-medical reports to decide your claim in addition to those listed on our previous notice:

Sterling Health Clinic received on 08/11/2023 WELLNESS CONSULTANTS LTD received on 09/28/2013

You said you were unable to work as of 07/01/2022 because of hip pain, nerve pain neck area, insomnia, and spine impairment.

Your condition results in some limitations in your ability to perform work related activities. We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, and work experience in determining how your condition affects your ability to work. We do not have sufficient vocational information to determine whether you can perform any of your past relevant work. However, based on the evidence in file, we have determined that you can adjust to other work.

If your condition gets worse and keeps you from working, please contact any National Benefits Agency office about filing another application.

8022678/ Assigned MMA1 MIQ1/ DCPS // 98022200 Form SSA-L1130 (07-2017) UF

Back to top

1 of 4: 6B: T16 Disability Reconsideration Notice - L1130

WALKER ASSOCIATES PC ELEANOR ROSE WALKER 1789 Main Street Suite 201 Anytown CA 90210

This is a copy of the letter sent to Arthur Miller CONFIDENTIALITY NOTICE: The accompanying material contains sensitive information. This information may be privileged and confidential, and intended for the use of the recipient named in this correspondence. If you have received this information in error, please contact us immediately.

Back to top National Benefits Agency Supplemental Security Income Important Information

Date: 08/30/2023 Claim Number: 456-12-7890

ARTHUR MILLER 789 Oak Ave Chicago, IL 60601-1001

Upon receipt of your request for reconsideration we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your case has been thoroughly evaluated; this includes the medical evidence and the additional information received since the original decision. We find that the previous determination was proper under the law. Attached to this notice is an explanation of the decision we made in your claim and how we arrived at it.

The Decision

See the enclosed Explanation.

If You Disagree With The Decision

If you do not agree with this decision, you have the right to request a hearing. A person who has not seen your case before will look at it. That person is an Administrative Law Judge (ALJ). The ALJ will review the parts of the decision that you think are wrong and correct any mistakes. The ALJ may also review the parts of our decision that you think are right. We will make a decision that may or may not be in your favor.

You have 60 days to ask for a hearing. The 60 days start the day you receive this letter. We assume you received this letter 5 days after the date on it unless you show us that you did not receive it within the 5-day period. You must have a good reason for waiting more than 60 days to ask for a hearing. You must ask for a

hearing in writing. Please use our "Request for Hearing" form, NBA-654, available at www.nationalbenefitsagency.gov. Or, you can complete your appeal online at www.nationalbenefitsagency.gov. You can also contact us to request the form or if you need help filling it out. In addition, you should complete form NBA-7890 "Disability Report - Appeal" to tell us about your medical condition since filing the claim. You can go to our website at www.nationalbenefitsagency.gov to locate this form. If you complete your appeal request online, you will be able to complete and submit this form with your appeal request. Please read the enclosed pamphlet, "Your Right to an Administrative Law Judge Hearing and Appeals Council Review of Your National Benefits Agency Case". It contains more information about the hearing.

How The Hearing Process Works

After we send your case for a hearing, an Administrative Law Judge (ALJ) will mail you a letter at least 75 days before the hearing to tell you its date, time, and place. The letter will explain the law in your case and tell you what has to be decided. Since the ALJ will review all the facts in your case, it is important that you give us any new facts as soon as you can.

The hearing is your chance to tell the ALJ why you disagree with the decisions in your case. You can give the ALJ new evidence and bring people to testify for you. The ALJ also can require people to bring important papers to your hearing and give facts about your case. You can question these people at your hearing.

If You Want Help With Your Appeal

You may choose to have a representative help you with your case. We will work with this person just as we would work with you. If you decide to have a representative, you should find one quickly so that person can start preparing your case.

456-12-7890/Processed Q4 FY24/Appeals//12345678 Form NBA-L7890 (07-2017) UF 3 of 4: 6B: T16 Disability Reconsideration Notice - L5678

Many advocates charge a fee only if you win your case. Others may represent you for free. Generally, your advocate cannot charge a fee unless we approve it. Your local National Benefits Agency office can give you a list of groups that can help you find an advocate.

If you get an advocate, you or that person must notify us in writing. You can go to https://secure.nba.gov/nba1234/online to complete the form with your advocate

online, download the form NBA-1234 "Claimant's Appointment of Advocate" at www.nationalbenefitsagency.gov/forms, or contact us to request a form.

You can also log into your myNBA Account account for information and online service options regarding your representation.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with the decision and you file a new application instead of an appeal:

- You might lose some benefits or not qualify for any benefits and
- We could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision, you should file an appeal.

Suspect National Benefits Agency Fraud?

Please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at (888) 777-8888. If you are deaf or hard of hearing, call TTY (800) 444-5555.

Need More Help?

1. Visit www.nationalbenefitsagency.gov for fast, simple, and secure online service.
2. Call us at 1-800-555-0100, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-555-0101. Please mention this letter when you call.
3. You may also call your local office at (888) 999-1234.

    ```
    METROPOLIS FIELDOFCC
    NATIONAL BENEFITS AGENCY
    SUITE 100
    450 RIVERFRONT AVE
    METROPOLIS MI 48201
    ```

How are we doing? Go to www.nationalbenefitsagency.gov/feedback to tell us.

National Benefits Agency

CC: Eleanor R. Walker; WALKER ASSOCIATES PC

Enclosure(s): Explanation NBA Pub. No. 80-11456 (Your Right To An Administrative Appeals Review And Panel Review Of Your National Benefits Agency Case)

9876543/Assigned PQR2 ABC2/DEFG//1234567890 Form NBA-L5678 (10-2023) VZ

Back to top 4 of 4: 6B: T16 Disability Reconsideration Notice - L1130

Explanation

We used the following medical and non-medical reports to decide your claim in addition to those listed on our previous notice: STERLING HEALTH CLINIC received on 08/11/2023 WELLNESS CONSULTANTS LTD received on 09/28/2013

You said you were unable to work as of 07/01/2022 because of hip pain, nerve pain neck area, insomnia, and spine impairment.

Your condition results in some limitations in your ability to perform work related activities. We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, and work experience in determining how your condition affects your ability to work. We do not have sufficient vocational information to determine whether you can perform any of your past relevant work. However, based on the evidence in file, we have determined that you can adjust to other work.

If your condition gets worse and keeps you from working, please contact any National Benefits Agency office about filing another application.

8022678/Assigned MMA1 MIQ1/DCPS // 98022200 Form NBA-L1130 (07-2017) UF

Back to top

HEARING FORMAT ELECTION STATEMENT

Claimant Name: Arthur Miller Claimant SSN: 456-12-7890

The undersigned appointed representative has consulted with the above-referenced claimant, and both the claimant and the representative provide this statement.

This hearing format election statement replaces all prior statements on this issue. If documents received in this claim create ambiguity or concern, please contact the representative prior to scheduling a hearing.

Consent to Online Video Hearing (OVH) (using Microsoft Teams)

[ ] We consent to an online video hearing (OVH) (using Microsoft Teams) and agree to appear in that manner.

Claimant's Email Address (if different from representative's email address) (for possible OVH)	Representative's Email Address (for possible OVH)

Consent to Telephone

[x] We consent to a telephone hearing and agree to appear in that manner.

Claimant's Number (for possible telephone hearing)	Representative's Number (for possible telephone hearing)
(773) 555-9876	Main Office #, Hearing Atty cell will be provided when scheduled (310) 555-0189

In-Person Only

[ ] We do not consent to a telephone hearing. We do not consent to an online video hearing (OVH). We ask for an in-person hearing

Objection to Video Teleconference (VTC) (video at an SSA location)

[x] We object to appearing for a hearing by video teleconference (VTC) (video at an SSA location). The claimant has the right to object to appearing by VTC within 30 days of receiving the acknowledgement of the request for hearing.

[x] The claimant has timely objected to VTC (through this submission or a previous notification). [ ] The claimant did not timely object to VTC but has good cause for the late submission, which is:

No Preference

[ ] We have no preference as to hearing format. Please schedule the hearing in any manner: telephone, OVH, VTC, or in-person

---

Signed: Attorney Eleanor R. Walker Dated: 9/8/23 Form NOSSCR-2023-HFES-2

Back to top

I501 SUMMARY 456-12-7890 SEPTEMBER 8, 2023

You have successfully submitted your Disability Appeal on September 8, 2023 at 3:10:41 PM Eastern time.

Summary Review

Information about Eleanor Walker

Relationship: Appointed Representative (Attorney) or Staff Mailing Address: 1789 Main Street, Suite 201, Anytown, CA 90210 Phone: (310) 555-0189 Fax Phone: (310) 555-0190

Information about Arthur Miller

Name: Arthur Miller Mailing Address: 789 Oak Ave, Chicago, IL 60601 Does Arthur Miller live at the above address? Yes Daytime Phone Number: (773) 555-9876 Alternative Phone Number: Email Address:

Request for Hearing by Administrative Law Judge

Date Notice of Decision received: 08/30/2023 Claim Number: Reason for Appeal: The decision does not conform to the evidence. Does Arthur Miller wish to appear at a hearing? Arthur Miller wishes to appear at a hearing

NATIONAL BENEFITS AGENCY

Refer To: Arthur Miller BNC#: AD12WE45G67890J

[Barcode Image Placeholder]

Appeals Division NBA APPEALS DIVISION OFFICE UNIT B 777 SUBURBAN WAY CITYVILLE, MI 48009 Tel: (877) 888-7000 / Fax: (833) 555-4000

September 28, 2023

Arthur Miller 789 OAK AVE CHICAGO, IL 60601-1001

Using my NBA Account for Your Pending Appeals Request

You are receiving this notice because you have a pending appeals request. If you have not done so already, we encourage you to create an online my NBA account. Creating your personal my NBA account is free and takes less than 15 minutes to complete. A my NBA account allows you to track and see details about your claim, including:

The date we received your request for an appeal; Current claim status and location; Your appeal date and time, once we have scheduled the appeal; The ability to view evidence in your record if you request it or when we contact you, which will help you prepare for your appeal; and Whether we have issued a decision.

Your personal my NBA account also allows you to:

Print proof that you do or do not receive benefits; View your NBA Statement to get estimates of future retirement, disability, and survivors benefits, and verify your earnings record to ensure future benefits are correct; and Request a replacement NBA card (in most states and D.C.).

If you do not already have an account, visit www.nationalbenefitsagency.gov/myaccount/today and click “Create an Account.”

Claimant

See Next Page 2 of 4: 9B: Outgoing ODAR Correspondence - OUTODARC Page 2 of 2

Once you are signed on to your account, be sure to turn on the Message Center notifications so you know when the agency sends you sensitive communications, such as when your evidence is available to view. If you already have an account, you may change your notification preferences, by selecting "Preferences” at the top of the page; click on "Notification Preferences;" and select whether you want to receive notifications by email, text message, or both.

One of our most important responsibilities is to protect your personal information. National Benefits Agency takes this obligation seriously, and we have a robust cybersecurity program in place to help us do so. Our security process follows federal guidelines, which include additional security measures to ensure that you are who you say you are when you conduct online business with us.

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 MAIN STREET SUITE 201 ANYTOWN, CA 90210

Back to top NATIONAL BENEFITS AGENCY

	Appeals Division
Refer To:	NBA APPEALS OFFICE
Arthur Miller	Unit B
BNC#: AD12WE45G67890J	777 SUBURBAN WAY
	CITYVILLE, MI 48009
	Tel: (877) 888-7000 / Fax: (833) 555-4000
	October 15, 2024

Arthur Miller 789 OAK AVE CHICAGO, IL 60601

Using my National Benefits Agency Account for Your Pending Hearing Request

You are receiving this notice because you have a pending hearing request. If you have not done so already, we encourage you to create an online my National Benefits Agency account. Creating your personal my National Benefits Agency account is free and takes less than 15 minutes to complete. A my National Benefits Agency account allows you to track and see details about your claim, including:

The date we received your request for a hearing; Current claim status and location; Your hearing date and time, once we have scheduled the hearing; The ability to view evidence in your record if you request it or when we contact you, which will help you prepare for your hearing; and Whether we have issued a decision.

Your personal my National Benefits Agency account also allows you to:

Print proof that you do or do not receive benefits; View your National Benefits Statement to get estimates of future retirement, disability, and survivors benefits, and verify your earnings record to ensure future benefits are correct; and Request a replacement National Benefits Agency card (in most states and D.C.).

If you do not already have an account, visit www.nationalbenefitsagency.gov/myaccount/ today and click "Create an Account."

See Next Page

Representative

Once you are signed on to your account, be sure to turn on the Message Center notifications so you know when the agency sends you sensitive communications, such as when your evidence is available to view. If you already have an account, you may change your notification preferences, by selecting "Preferences" at the top of the page; click on "Notification Preferences;" and select whether you want to receive notifications by email, text message, or both.

One of our most important responsibilities is to protect your personal information. National Benefits Agency takes this obligation seriously, and we have a robust cybersecurity program in place to help us do so. Our security process follows federal guidelines, which include additional security measures to ensure that you are who you say you are when you conduct online business with us.

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 MAIN STREET SUITE 201 ANYTOWN, CA 90210 National Benefits Agency Representative

Back to top

NATIONAL BENEFITS AGENCY

Refer To: Arthur Miller BNC#: AD24J98K123456L

Appeals Division NBA APPEALS DIVISION Unit B 777 SUBURBAN WAY CITYVILLE, MI 48009 Tel: (877) 888-7000 / Fax: (833) 555-4000

September 29, 2023

Arthur Miller 789 OAK AVE CHICAGO, IL 60601-1001

Dear Arthur Miller:

Thank you for your request for a hearing before an administrative law judge (ALJ). This letter explains the hearing process and things that you should do now to get ready for your hearing. We will send you a notice after we schedule your hearing. We will notify you at least 75 days before the date of your hearing. The notice will provide you with the time and place of your hearing. We generally process requests for hearing by date order, with the oldest receiving priority. We will schedule your hearing as soon as we can, which may take several months.

Use of Video Teleconferencing (VTC) At Your Hearing

In certain situations, we hold your hearing by VTC rather than in person. We will let you know ahead of time if we schedule your hearing by VTC.

If we schedule your appearance by VTC, you and the ALJ will be at different locations during the hearing. A large, color monitor will enable you and the ALJ to see, hear, and speak to each other. The ALJ will also be able to see, hear, and speak to anyone who comes with you to the hearing. This may include your representative (if you have one), a friend, or a family member. We will provide someone at your location to run the equipment and provide any other help you may need.

You must let us know within 30 days after the date you receive this notice if you do not want to appear at your hearing by VTC. (We may extend the 30-day period if you show you had good cause for missing the deadline.) Please let us know by completing and returning the attached form in the envelope we sent your representative. We will arrange for you to appear in person.

Form HA-L2 (04-2015) Claimant

Suspect National Benefits Agency Fraud?

Please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at 1-800-999-3000 (TTY 1-866-999-3001).

See Next Page 2 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

If you move before we hold your hearing, we retain the right to decide how you will appear at your hearing, even if you objected to appearing by VTC. For us to consider your change of residence when we schedule your hearing, you must submit evidence proving your new residence.

The Hearing

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

Your Right to An Interpreter At Your Hearing

You are not required to bring an interpreter. You must request an interpreter so we can provide an interpreter free of charge. When you request an interpreter, tell us what language you prefer (including ASL). An interpreter can be requested by calling our office or sending a letter.

Submitting Evidence

We need to make sure that your file has everything that the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

You are required to inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception.

We can help you get evidence. If you need help, contact our office, your local Social Security office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained another way. You must ask the ALJ to issue a subpoena at least 10 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

See Next Page

Back to top 3 of 25: 10B: Request for Hearing Acknowledgement Letter - HRGACK

You May See The Evidence In Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions Or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

Sincerely,

Sarah Thompson Hearing Office Director

Enclosures: CB-10 (Objection to Remote Participation) CB-A2 (Process Overview) NBA Publication No. 88-012 (Your Guide to National Benefits Agency Remote Hearings) CB-30 (Health Information Consent) NBA-827 (Authorization to Disclose Information to the National Benefits Agency (NBA))

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 Main Street Suite 201 Anytown, CA 90210

FORM CB-A1 (06-2023) Claimant 4 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

National Benefits Agency Form Approved OMB No. 0960-0671 OBJECTION TO APPEARING BY VIDEO TELECONFERENCING

Name: Arthur Miller _ Social Security Number: _ Wage Earner: _ Hearing Office: CITYVILLE APPEALS OFFICE _ [] I do not want to appear at my hearing by video teleconference. Please schedule my hearing so that I may appear in person. I understand that by objecting to appearing by video teleconference I may experience a delay in my hearing. RQID:DCPS09262304263465009280 SITE:X54 DR:S SSN:\\\\\ DOCTYPE:3267 RF:D CS:d459

Please return this form only if you object to a hearing by video teleconference.

Additional Comments:__

Signature:_ Date:__ Area Code and Telephone Number:__

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you are opting-out of an appearance via video teleconferencing. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.nationalbenefitsagency.gov or at your local National Benefits Agency office.

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 5 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. *Send only comments relating to our time estimate to this address, not the completed form.*

Form HA-55 (01-2020)

Back to top 5 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

..... NATIONAL BENEFITS AGENCY
APPEALS PROCESS WHAT HAPPENS
NEXT? .....

Your hearing request and your file are now at the Appeals Division.

We may look at your case to see if we can make a decision in your favor without a hearing. If we do not make a decision this way, we will prepare your case for an administrative law judge (ALJ). We prepare cases in the order we get them.

An ALJ will review your file after we prepare it. We will then schedule a hearing for your case. You will get a notice informing you when and where we will hold your hearing. We will send you the notice at least 75 days before the date of your hearing. If you have a representative, we will also send the notice to that person.

You will come to your hearing and talk to the ALJ. Other people, such as witnesses or your representative, can also come to your hearing. If the ALJ wants any more evidence, or if you ask for more time to give us more evidence, the ALJ will tell you how long we will wait for that evidence.

The ALJ will make a decision after your hearing if he or she has all of the evidence. Otherwise, the ALJ will make a decision when he or she gets the evidence needed to make a decision.

You can expect to wait another 3 months after the hearing until you receive your written decision in the mail.

We cannot talk to you about the outcome of your case before we mail you the written decision.

Remember: In order to make your case go as quickly as possible, please be sure to send us all of your medical and other evidence as soon as possible. Your representative, if you have one, may also send evidence to us. Having the evidence sooner could help the ALJ decide your case sooner.

Back to top Form HA-L4 (08-2012) 6 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

NATIONAL BENEFITS AGENCY Your Guide to National Benefits Agency Disability Video Hearings

When you request a hearing with the Appeals Division at the National Benefits Agency (NBA), we will hold your hearing by video teleconference, in-person, or, in extraordinary circumstances, by telephone.

What is a Video Hearing?

Video hearings are just like in-person hearings, except that you and anyone who comes to the hearing with you, such as your representative or witnesses, will

view, listen, and speak to an Administrative Law Judge (ALJ) in a different location by using a video monitor. We may schedule you to appear by video unless you object to appearing by video within 30 days after you receive a letter from us that acknowledges your request for a hearing. We process and conduct in-person and video hearings in the same way. There are a number of advantages to a video hearing, as opposed to an in-person hearing, including the following: — Greater Convenience and Flexibility – Our network of video hearing locations continues to grow. Video hearing locations may be closer to you than one of our hearing offices. — Possibility of a quicker hearing – Often, we can schedule a video hearing faster than an in-person hearing. You will have access to more locations and more ALJs, which makes it easier to schedule your hearing.

How Does a Video Hearing Work?

We will send you a notice that tells you the time and place for your hearing at least 75 days before your scheduled hearing date. Pay special attention to the place/address, as it may be different from where your case was handled previously. If you have a representative, witnesses, or both, they can appear with you at the video hearing location. On the date of your hearing, the video hearing location could be an Appeals Division hearing office, your representative's office, or a NBA field office. You should arrive at least 30 minutes before the scheduled time of your hearing. A video hearing uses state-of-the-art equipment that allows you and the ALJ to see, hear, and speak to each other in real time, just as if you were talking face to face. Transmission of the hearing is secure, and we protect your privacy. Just like in-person hearings, we record only the audio portion of video hearings. We do not record the video portion of any of our hearings. A technician will be available to make sure the video teleconferencing equipment is connected and working properly.

NO SHOW Help Us to Serve You Better! If you do not show up on the date of your scheduled hearing, your request for hearing may be dismissed. You must tell us in writing as soon as you realize you cannot appear at the time and place shown on your hearing notice. Unless the ALJ pre-approves your request to change the time or place of your hearing, you should appear. By letting us know you cannot appear, you give another person the opportunity to use that hearing slot for his or her hearing.

www.nationalbenefitsagency.gov | f y youtube

National Benefits Agency Publication No. NBA-123 | ICN 987654 | August 2017 (Destroy prior editions) Produced and published at U.S. taxpayer expense

△ Printed on recycled paper

Back to top NATIONAL BENEFITS AGENCY (NBA) Refer To: Arthur Miller

Appeals Division NBA APPEALS OFC STE 500 777 SUBURBAN WAY CITYVILLE, MI 48009 Tel: (877) 888-7000 / Fax: (833) 555-4000

September 29, 2023

Arthur Miller 789 OAK AVE CHICAGO, IL 60601

Dear Arthur Miller:

In order to obtain records to update your file we need a current Authorization to Disclose Information. Please sign the enclosed form(s) and return it to our office within ten (10) days. A return envelope is enclosed for your convenience.

Sincerely,

Eleanor Vance Hearing Office Director

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 MAIN STREET STE 100 ANYTOWN, CA 90210

Enclosure: NBA-5000 (Authorization to Disclose Information to the National Benefits Agency (NBA))

Form NA-5000 (01-23) Form NBA-827 (03-2020) Discontinue Prior Editions Page 1 of 2 OMB No. 0960-0623

Whose Records to be Disclosed

NAME (First, Middle, Last, Suffix)	**Birthday (MM/DD/YYYY)**
Arthur Miller	05/21/1965
SSN	
456-12-7890	

AUTHORIZATION TO DISCLOSE INFORMATION TO

THE NATIONAL BENEFITS AGENCY (NBA)

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	**THIS BOX TO BE COMPLETED BY NBA (as needed) Additional information to identify the subject (e.g.,**
All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including	other names used), the specific source, or the material to be disclosed:

FROM WHOM	**THIS BOX TO BE COMPLETED BY NBA (as needed) Additional information to identify the subject (e.g.,**
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 NBA	
Employers, insurance companies, workers' compensation programs	
Others who may know about my condition (family, neighbors, friends, public officials)	

TO WHOM	**The National Benefits Agency 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 NBA'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 NBA and my sources to revoke this authorization at any time (see page 2 for details). NBA 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	**IF not signed by subject of disclosure, specify basis for authority to sign**
INDIVIDUAL authorizing disclosure Signature	[ ] Parent of minor [ ] Guardian [ ] Other personal representative (explain) (Parent/guardian/personal representative sign here if two signatures required by State law)
Date Signed	**Street Address State ZIP** 789 OAK AVE IL 60601
Phone Number (with area code) (773) 555-9876	City CHICAGO

WITNESS	**I know the person signing this form or am satisfied of this person's identity:**	**IF needed, second witness sign here (e.g., if signed with "X" above)**
Signature		
	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.

Back to top 9 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

Explanation of Form NBA-827, "Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 NBA-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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA makes every reasonable effort to ensure that the information in the NBA-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 contracts where necessary to establish or verify information provided by representative payees or payee 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.nationalbenefitsagency.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

1. 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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top NATIONAL BENEFITS AGENCY

Refer To: Appeals Division Arthur Miller
NBA Appeals Division Office BNC#: AD12WE45G67890J
Unit B 777 SUBURBAN WAY 789
Oak Ave, Chicago, IL 60601-1001 CITYVILLE, MI 48009
Tel: (877) 888-7000 / Fax: (833) 555-4000

September 29, 2023

Arthur Miller 789 Oak Ave CHICAGO, IL 60601

Dear Arthur Miller:

Thank you for your request for a hearing before an administrative law judge (ALJ). This letter explains the hearing process and things that you should do now to get ready for your hearing. We will send you a notice after we schedule your hearing. We will notify you at least 75 days before the date of your hearing. The notice will provide you with the time and place of your hearing. We generally process requests for hearing by date order, with the oldest receiving priority. We will schedule your hearing as soon as we can, which may take several months.

Use of Video Teleconferencing (VTC) At Your Hearing

In certain situations, we hold your hearing by VTC rather than in person. We will let you know ahead of time if we schedule your hearing by VTC.

If we schedule your appearance by VTC, you and the ALJ will be at different locations during the hearing. A large, color monitor will enable you and the ALJ to see, hear, and speak to each other. The ALJ will also be able to see, hear, and speak to anyone who comes with you to the hearing. This may include your representative (if you have one), a friend, or a family member. We will provide someone at your location to run the equipment and provide any other help you may need.

You must let us know within 30 days after the date you receive this notice if you do not want to appear at your hearing by VTC. (We may extend the 30-day period if you show you had good cause for missing the deadline.) Please let us know by completing and

Form HA-L2 (04-2015)
Representative

Suspect National Benefits Agency Fraud?
Please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit
at 1-800-999-3000 (TTY 1-866-999-3001).

See Next Page 11 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

returning the attached form in the envelope we sent your representative. We will arrange for you to appear in person.

If you move before we hold your hearing, we retain the right to decide how you will appear at your hearing, even if you objected to appearing by VTC. For us to consider your change of residence when we schedule your hearing, you must submit evidence proving your new residence.

The Hearing

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

Your Right to An Interpreter At Your Hearing

You are not required to bring an interpreter. You must request an interpreter so we can provide an interpreter free of charge. When you request an interpreter, tell us what language you prefer (including ASL). An interpreter can be requested by calling our office or sending a letter.

Submitting Evidence

We need to make sure that your file has everything that the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

You are required to inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception.

We can help you get evidence. If you need help, contact our office, your local field office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained

Form HA-L2 (04-2015) Representative See Next Page

another way. You must ask the ALJ to issue a subpoena at least 10 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

You May See The Evidence In Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions Or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

Sincerely,

Elias Thorne
Hearing Office Dir

Enclosures: NA-55 (Objection to Appearing by Video Teleconferencing) NA-L4 (What Happens Next) NBA Publication No. 80-123 (Your Guide to National Benefits Agency Video Hearings) NA-827 (Medical Release Notice) NBA-827 (Authorization to Disclose Information to the National Benefits Agency (NBA))

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 Main Street STE 100 Anytown, CA 90210

Social Security Administration Form Approved OMB No. 0960-0671

OBJECTION TO APPEARING BY VIDEO TELECONFERENCING

Name: Arthur Miller
Social Security Number:
Wage Earner: RQID:DCPS09262304263469007890 SITE:X54 DR:S
Hearing Office: CITYVILLE SSN: DOCTYPE:3267 RF:D CS:4915

[ ] I do not want to appear at my hearing by video teleconference. Please schedule my hearing so that I may appear in person. I understand that by objecting to appearing by video teleconference I may experience a delay in my hearing.

Please return this form only if you object to a hearing by video teleconference.

Additional Comments:

Signature: **_ Date: Area Code and Telephone Number: __**

Privacy Act Statement Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you are opting-out of an appearance via video teleconferencing. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.nationalbenefitsagency.gov or at your local National Benefits Agency office.

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 5 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. ***Send only comments relating to our time estimate to this address, not the completed form.***

Form HA-55 (01-2020)

Back to top NATIONAL BENEFITS AGENCY HEARING PROCESS WHAT HAPPENS NEXT?

Your hearing request and your file are now at the Appeals Division.

We may look at your case to see if we can make a decision in your favor without a hearing. If we do not make a decision this way, we will prepare your case for an administrative law judge (ALJ). We prepare cases in the order we get them.

An ALJ will review your file after we prepare it. We will then schedule a hearing for your case. You will get a notice informing you when and where we will hold your hearing. We will send you the notice at least 75 days before the date of your hearing. If you have a representative, we will also send the notice to that person.

You will come to your hearing and talk to the ALJ. Other people, such as witnesses or your representative, can also come to your hearing. If the ALJ wants any more evidence, or if you ask for more time to give us more evidence, the ALJ will tell you how long we will wait for that evidence.

The ALJ will make a decision after your hearing if he or she has all of the evidence. Otherwise, the ALJ will make a decision when he or she gets the evidence needed to make a decision.

You can expect to wait another 3 months after the hearing until you receive your written decision in the mail.

We cannot talk to you about the outcome of your case before we mail you the written decision.

Remember: In order to make your case go as quickly as possible, please be sure to send us all of your medical and other evidence as soon as possible. Your representative, if you have one, may also send evidence to us. Having the evidence sooner could help the ALJ decide your case sooner.

Back to top

NATIONAL BENEFITS USA AGENCY

Your Guide to National Benefits Agency Disability Video Hearings

When you request a hearing with the Appeals Division at the National Benefits Agency (NBA), we will hold your hearing by video teleconference, in-person, or, in extraordinary circumstances, by telephone.

What is a Video Hearing?

Video hearings are just like in-person hearings, except that you and anyone who comes to the hearing with you, such as your representative or witnesses, will view, listen, and speak to an Administrative Law Judge (ALJ) in a different location by using a video monitor. We may schedule you to appear by video unless you object to appearing by video within 30 days after you receive a letter from us that acknowledges your request for a hearing. We process and conduct in-person and video hearings in the same way. There are a number of advantages to a video hearing, as opposed to an in-person hearing, including the following: Greater Convenience and Flexibility – Our network of video hearing locations continues to

grow. Video hearing locations may be closer to you than one of our hearing offices. Possibility of a quicker hearing – Often, we can schedule a video hearing faster than an in-person hearing. You will have access to more locations and more ALJs, which makes it easier to schedule your hearing.

How Does a Video Hearing Work?

We will send you a notice that tells you the time and place for your hearing at least 75 days before your scheduled hearing date. Pay special attention to the place/address, as it may be different from where your case was handled previously. If you have a representative, witnesses, or both, they can appear with you at the video hearing location. On the date of your hearing, the video hearing location could be an Appeals Division hearing office, your representative's office, or a NBA field office. You should arrive at least 30 minutes before the scheduled time of your hearing. A video hearing uses state-of-the-art equipment that allows you and the ALJ to see, hear, and speak to each other in real time, just as if you were talking face to face. Transmission of the hearing is secure, and we protect your privacy. Just like in-person hearings, we record only the audio portion of video hearings. We do not record the video portion of any of our hearings. A technician will be available to make sure the video teleconferencing equipment is connected and working properly.

Help Us to Serve You Better!

If you do not show up on the date of your scheduled hearing, your request for hearing may be dismissed. You must tell us in writing as soon as you realize you cannot appear at the time and place shown on your hearing notice. Unless the ALJ pre-approves your request to change the time or place of your hearing, you should appear. By letting us know you cannot appear, you give another person the opportunity to use that hearing slot for his or her hearing.

www.nationalbenefitsagency.gov | [Facebook Icon] [Twitter Icon] [YouTube Icon]
National Benefits Agency Publication No. 70-007 | ICN 443300 | August 2017
(Destroy prior editions) Produced and published at U.S. taxpayer expense
[Recycled Paper Icon] Printed on recycled paper

NATIONAL BENEFITS AGENCY

Refer To: Arthur Miller

Appeals Division NBA APPEALS DIVISION UNIT B 777 SUBURBAN WAY CITYVILLE, MI 48009 Tel: (877) 888-7000 / Fax: (833) 555-4000

September 29, 2023

Arthur Miller 789 OAK AVE CHICAGO, IL 60601-1001

Dear Arthur Miller:

In order to obtain records to update your file we need a current Authorization to Disclose Information. Please sign the enclosed form(s) and return it to our office within ten (10) days. A return envelope is enclosed for your convenience.

Sincerely,

Eleanor Vance Appeals Division Director

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 MAIN STREET SUITE 201 ANYTOWN, CA 90210

Enclosure: NBA-XYZ (Authorization to Release Information to the National Benefits Agency (NBA))

Form AB-XYZ (05-08)

Back to top 17 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

Form SSA-827 (03-2020) Page 1 of 2

Discontinue Prior Editions OMB No. 0960-0623

Whose Records to be Disclosed

NAME (First, Middle, Last, Suffix)	**Birthday (MM/DD/YYYY)**
Arthur Miller	05/21/1965
SSN	
	456-12-7890

AUTHORIZATION TO DISCLOSE INFORMATION TO

THE NATIONAL BENEFITS AGENCY (NBA)

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 treatme
   not limited to:
   - Psychological, psychiatric or other mental impairme
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a commun
   - Gene-related impairments (including genetic test re
2. Information about how my impairment(s) affects my abil
3. Copies of educational tests or evaluations, including
   and any other records that can help evaluate function;

4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM THIS BOX TO BE COMPLETED BY NBA/EVALUATION SERVICES (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed: 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 NBA Employers, insurance companies, workers' compensation programs Others who may know about my condition (family,

neighbors, friends, public officials)

TO WHOM The National Benefits Agency and to the State agency authorized to process my case (usually called "evaluation 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 NBA'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 NBA and my sources to revoke this authorization at any time (see page 2 for details).

NBA 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	**IF not signed by subject of disclosure, specify basis for authority to sign**
INDIVIDUAL authorizing disclosure Signature __	☐ Parent of minor ☐ Guardian ☐ Other personal representative
	(explain)
__	__ (Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed	**Street Address**		
	789 OAK AVE		
Phone Number (with area code)	City	State	ZIP
	(773) 555-9876	CHICAGO	IL 60601

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)
	Signature __
	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. 18 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

Explanation of Form SSA-827,
"Authorization to Disclose Information to the National Benefits Agency

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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA 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 contracts where necessary to establish or verify information provided by representative payees or payee 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.nationalbenefitsagency.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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top 19 of 19: 10B: Request for Hearing Acknowledgement Letter - HRGACK

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned

RQID:DCPS0926230426347707890 SITE:X54 DR:S SSN: DOCTYPE:5032 RF:D CS:eb48

Fax Number: (877) 555-4001

Claimant: Arthur Miller

Back to top

	Appeals Division
	NBA Appeals Office
NATIONAL BENEFITS AGENCY	**UNIT B**
Refer To:	**777 SUBURBAN WAY**
Arthur Miller	**CITYVILLE, MI 48009**
BNC#: AD12WE45G67890J	**Tel: (877) 888-7000 / Fax: (833) 555-4000**

February 05, 2024

Arthur Miller
789 OAK AVE
CHICAGO, IL 60601-1001

NOTICE OF HEARING

I have scheduled your hearing for:

Day: Wednesday Date: May 29, 2024 Time: 10:30 AM
Eastern (ET)

I will conduct your hearing by telephone. On the date and at the time of the hearing listed above,
I will call you at this telephone number: (773) 555-9876. If this is not the correct telephone
number, please call this office immediately at (877) 888-7000.

On the day of the hearing, we will call you at the telephone number you provided: If you provided a cell phone number for the hearing, the incoming call will display as
"New Town, KY." If you provided a landline phone number, your caller ID will display as "NBA U.S. Agency."

It Is Important That You Attend Your Hearing

I have set aside this time for you to tell me about your case. If you and your representative do
not attend the hearing, I may dismiss your request for hearing unless I find that

you had a
good reason for not attending.

Complete the Enclosed Form

Please complete and return to us the enclosed acknowledgement form using the enclosed
envelope as soon as possible. We sent your representative a copy of the acknowledgement
form. Your representative also should return his or her copy of the form.

See Next Page

Arthur Miller BNC#: AD12WE45G67890J

If You Cannot Attend Your Scheduled Hearing

If you cannot attend your hearing at the scheduled time, please call this office immediately at (877) 888-7000 to request a change. You must also submit your request in writing and tell us why you want us to change the time of your hearing.

If you object to the time of the hearing, you must notify us in writing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or 30 days after receiving notice of the hearing, whichever is earlier. We assume you received this notice 5 days after the date on the top of the notice, unless you show us that you did not get it within the 5-day period. If you miss the deadline for requesting a change, please tell us why you missed the deadline. I will extend the deadline for requesting a change if I find that you have good cause, as defined in our regulations, for the delay.

If I find that you have a good reason for the requested change, we will reschedule your hearing and will send you another notice at least 20 days before the date of the hearing. If I find that you do not have a good reason for the requested change, you must appear at the time shown above or I may dismiss your request for hearing.

Submitting More Evidence and Reviewing Your File

You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you submit information and evidence to us. If you know about or have more evidence, such as recent medical records, reports, or evaluations, you must inform me about it or give it to me no later than 5 business days before the date of your hearing. If you miss this deadline, I may not consider the evidence when I decide your case.

If you miss the deadline to inform me about or submit evidence, I will accept the evidence if I have not yet issued a decision and you missed the deadline because:

1. Our action misled you;
2. You had a physical, mental, educational, or linguistic limitation that prevented you from informing me about or submitting the evidence earlier; or
3. Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing me about or submitting the evidence earlier.

If you want to review your file before the date of your hearing, please call this office at (877) 888-7000 to make arrangements to do so. If you have a representative, he or she may be able to access your file electronically.

Issues I Will Consider

The hearing concerns your application of July 15, 2022, for Supplemental Security Income (SSI) under section 1614(a)(3) of the Social Security Act (the Act). I will consider whether you are disabled under section 1614(a)(3) of the Act.

Under the Act, I will find you disabled if you have a physical or mental condition(s) that:

Keeps you from doing any substantial gainful work; and Has lasted 12 straight months, can be expected to last 12 straight months, or can be expected to result in death.

I will follow a step-by-step process to decide whether you are disabled. I will stop the process at the first step I can make a decision. The steps in this process look at:

Any work you have done after your condition(s) began; The severity of your condition(s); Whether you can do the kind of work you did in the past; and Whether you can do any other kind of work considering your age, education, and work experience.

Our regulations explain the rules for deciding whether you are disabled and, if so, when you became disabled. These rules are in the Code of Federal Regulations, Title 20, Chapter III, Part 416, Subpart I.

More About the Issues

If I find that you have been disabled, I will also consider whether your disability continues through the date of the decision or whether your condition(s) has improved.

If I find that you are disabled and that you have a substance use disorder (drug, alcohol, or both), I also will decide whether it is a contributing factor material to the determination of disability. This means I will decide whether you would be disabled if you were not using drugs or alcohol. If drug addiction or alcoholism is a contributing factor material to the determination of your disability, I will find you not disabled under Sections 223(d)(2), or 1614(a)(3), or 223(d)(2) and 1614(a)(3) of the Social Security Act.

Remarks

I may ask a Vocational Expert, a Medical Expert, or both to attend your hearing and answer questions. If I ask an expert to attend your hearing, I will send you an Amended Notice prior to the date and time of your hearing.

A vocational expert will appear at the hearing by phone. The vocational expert's resume will be added to your file before your hearing, generally 20 days before the hearing.

If You Object to the Issues

If you object to the issues or remarks listed above, you must tell me that and explain why in writing. You must tell me as soon as possible, but not later than 5 business days before the date of the hearing. If you miss this deadline, I will

consider your objection(s) if you show that you meet one of the exceptions set forth in our regulations.

Your Right To Request a Subpoena

In general, you have to prove that you are blind or disabled. If you cannot get evidence that you reasonably need to present your case fully, I may be able to help you by issuing a legal document called a subpoena. A subpoena may require a person to submit documents or testify at your hearing.

If you want to ask me to issue a subpoena, you must tell me that in writing as soon as possible. I must receive your subpoena request no later than 10 business days before your hearing, unless you show that you meet one of the exceptions set forth in our regulations. I will review your request and may issue a subpoena if reasonably necessary for full presentation of your case. In your request, please tell me:

What documents you need or who the witnesses are; The location of the documents or witnesses; The important facts you expect the documents or witnesses to prove; and Why you cannot prove these facts without a subpoena.

What Happens At the Hearing?

I will ask you and any other witnesses to take an oath or to affirm that the testimony is true. You will have a chance to testify and tell me about your case. You and your representative (if you have one) may review submitted documents, present and question witnesses, state your case, and make statements about the facts and law. If you want to submit a written statement before your hearing, you must give me a copy and give a copy to each party no later than 5 business days before the date of your hearing. If you miss this deadline, you may still submit a written statement before your hearing if you show that you meet one of the exceptions set forth in our regulations.

See Next Page

Arthur Miller BNC#: AD12WE45G67890J

I will ask you and any other witnesses questions that will help me make a decision in your case. We will make an audio recording of the hearing.

The Decision

After the hearing, I will issue a written decision and mail it to you. The decision will explain my findings of fact and conclusions of law. I will base my decision on all the evidence of record, including the testimony at your hearing.

Suspect National Benefits Agency Fraud?

Please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at 1-800-999-3000 (TTY 1-866-999-3001).

If You Have Any Questions

If you have any questions, please call, (877) 888-7000, or write this office. For your convenience, our address is on the first page of this notice.

Sincerely,

Arthur Pendragon Administrative Law Judge

Enclosures: Form HA-504-OP1 (Acknowledgement of Receipt of Notice of Hearing)

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 MAIN STREET SUITE 201 ANYTOWN, CA 90210

- - - | - - - | OMB NO. 1234-5678 ACKNOWLEDGEMENT OF RECEIPT (NOTICE OF HEARING) (COMPLETE THIS FORM AND RETURN IT AT ONCE IN THE ENVELOPE PROVIDED. NO POSTAGE IS NECESSARY)

- - - | - - - Wage Earner: | Administrative Law Judge: Arthur Pendragon - - - | - - - Hearing Scheduled: Wednesday, May 29, 2024 at 10:30 AM Eastern (ET) | Hearing Office: CITYVILLE - - - | - - - Location of Hearing: Telephone | Unit B 777 Suburban Way Cityville, MI 48009

- - - | - - -

(Check only one)

[ ] I will be available by phone at the time shown on the Notice of Hearing. If an emergency arises after I mail this form and I am not available, I will immediately notify you at the telephone number shown on the Notice of Hearing.

[ ] I cannot be present at the time shown on the Notice of Hearing. I request that you reschedule my hearing because:

_____

_____

_____

NOTE: YOUR REQUEST FOR HEARING MAY BE DISMISSED IF YOU DO NOT ATTEND THE HEARING AND CANNOT GIVE A GOOD REASON FOR NOT ATTENDING. THE TIME OR PLACE OF THE HEARING WILL BE CHANGED IF YOU HAVE A GOOD REASON FOR YOUR REQUEST.

- - -|- - -|- - -||

[ ] I have recently moved. My new address is:

Form HA-789-CVL1 (01-2020) rev (05-2023) 7 of 14: 11B: Hearing Notice - 507

Privacy Act Statement Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you will appear at your hearing with an Administrative Law Judge.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.nationalbenefitsagency.gov or at your local National Benefits Agency office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the

information from these programs to establish or verify a person’s eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form HA-504-OP1 (09-2003) ef (03-2015) NATIONAL BENEFITS AGENCY

Refer To: Appeals Division Arthur Miller NBA APPEALS DIVISION BNC#: AD12WE45G67890J Unit B 777 SUBURBAN WAY [Barcode Placeholder] CITYVILLE, MI 48009 Tel: (877) 888-7000 / Fax: (833) 555-4000

February 05, 2024

Arthur Miller 789 OAK AVE CHICAGO, IL 60601-1001

NOTICE OF HEARING

I have scheduled your hearing for:

Day: Wednesday Date: May 29, 2024 Time: 10:30 AM Eastern (ET)

I will conduct your hearing by telephone. On the date and at the time of the hearing listed above, I will call you at this telephone number: (773) 555-9876. If this is not the correct telephone number, please call this office immediately at (877) 888-7000.

On the day of the hearing, we will call you at the telephone number you provided: If you provided a cell phone number for the hearing, the incoming call will display as "Columbia, MD." If you provided a landline phone number, your caller ID will display as "NBA U.S Govt."

It Is Important That You Attend Your Hearing

I have set aside this time for you to tell me about your case. If you and your representative do not attend the hearing, I may dismiss your request for hearing unless I find that you had a good reason for not attending.

Complete the Enclosed Form

Please complete and return to us the enclosed acknowledgement form using the enclosed envelope as soon as possible. We sent your representative a copy of the acknowledgement form. Your representative also should return his or her copy of the form.

See Next Page

If You Cannot Attend Your Scheduled Hearing

If you cannot attend your hearing at the scheduled time, please call this office immediately at (877) 888-7000 to request a change. You must also submit your request in writing and tell us why you want us to change the time of your hearing.

If you object to the time of the hearing, you must notify us in writing at the earliest possible opportunity, but not later than 5 days before the date set for the hearing or 30 days after receiving notice of the hearing, whichever is earlier. We assume you received this notice 5 days after the date on the top of the notice, unless you show us that you did not get it within the 5-day period. If you miss the deadline for requesting a change, please tell us why you missed the deadline. I will extend the deadline for requesting a change if I find that you have good cause, as defined in our regulations, for the delay.

If I find that you have a good reason for the requested change, we will reschedule your hearing and will send you another notice at least 20 days before the date of the hearing. If I find that you do not have a good reason for the requested change, you must appear at the time shown above or I may dismiss your request for hearing.

Submitting More Evidence and Reviewing Your File

You must inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you submit information and evidence to us. If you know about or have more evidence, such as recent medical records, reports, or evaluations, you must inform me about it or give it to me no later than 5 business days before the date of your hearing. If you miss this deadline, I may not consider the evidence when I decide your case.

If you miss the deadline to inform me about or submit evidence, I will accept the evidence if I have not yet issued a decision and you missed the deadline because:

1. Our action misled you;
2. You had a physical, mental, educational, or linguistic limitation that prevented you from informing me about or submitting the evidence earlier; or
3. Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing me about or submitting the evidence earlier.

If you want to review your file before the date of your hearing, please call this office at (877) 888-7000 to make arrangements to do so. If you have a representative, he or she may be able to access your file electronically.

Issues I Will Consider

The hearing concerns your application of July 15, 2022, for Supplemental Security Income (SSI) under section 1614(a)(3) of the Social Security Act (the Act). I will consider whether you are disabled under section 1614(a)(3) of the Act.

Arthur Miller BNC#: AD12WE45G67890J Under the Act, I will find you disabled if you have a physical or mental condition(s) that:

Keeps you from doing any substantial gainful work; and Has lasted 12 straight months, can be expected to last 12 straight months, or can be expected to result in death.

I will follow a step-by-step process to decide whether you are disabled. I will stop the process at the first step I can make a decision. The steps in this process look at:

Any work you have done after your condition(s) began; The severity of your condition(s); Whether you can do the kind of work you did in the past; and Whether you can do any other kind of work considering your age, education, and work experience.

Our regulations explain the rules for deciding whether you are disabled and, if so, when you became disabled. These rules are in the Code of Federal Regulations, Title 20, Chapter III, Part 416, Subpart I.

More About the Issues

If I find that you have been disabled, I will also consider whether your disability continues through the date of the decision or whether your condition(s) has improved.

If I find that you are disabled and that you have a substance use disorder (drug, alcohol, or both), I also will decide whether it is a contributing factor material to the determination of disability. This means I will decide whether you would be disabled if you were not using drugs or alcohol. If drug addiction or alcoholism is a contributing factor material to the determination of your disability, I will find you not disabled under Sections 223(d)(2), or 1614(a)(3), or 223(d)(2) and 1614(a)(3) of the Social Security Act.

Remarks

I may ask a Vocational Expert, a Medical Expert, or both to attend your hearing and answer questions. If I ask an expert to attend your hearing, I will send you an Amended Notice prior to the date and time of your hearing.

A vocational expert will appear at the hearing by phone. The vocational expert's resume will be added to your file before your hearing, generally 20 days before the hearing.

See Next Page

Arthur Miller BNC#: AD12WE45G67890J

If You Object to the Issues

If you object to the issues or remarks listed above, you must tell me that and explain why in writing. You must tell me as soon as possible, but not later than 5

business days before the date of the hearing. If you miss this deadline, I will consider your objection(s) if you show that you meet one of the exceptions set forth in our regulations.

Your Right To Request a Subpoena

In general, you have to prove that you are blind or disabled. If you cannot get evidence that you reasonably need to present your case fully, I may be able to help you by issuing a legal document called a subpoena. A subpoena may require a person to submit documents or testify at your hearing.

If you want to ask me to issue a subpoena, you must tell me that in writing as soon as possible. I must receive your subpoena request no later than 10 business days before your hearing, unless you show that you meet one of the exceptions set forth in our regulations. I will review your request and may issue a subpoena if reasonably necessary for full presentation of your case. In your request, please tell me:

What documents you need or who the witnesses are; The location of the documents or witnesses; The important facts you expect the documents or witnesses to prove; and Why you cannot prove these facts without a subpoena.

What Happens At the Hearing?

I will ask you and any other witnesses to take an oath or to affirm that the testimony is true. You will have a chance to testify and tell me about your case. You and your representative (if you have one) may review submitted documents, present and question witnesses, state your case, and make statements about the facts and law. If you want to submit a written statement before your hearing, you must give me a copy and give a copy to each party no later than 5 business days before the date of your hearing. If you miss this deadline, you may still submit a written statement before your hearing if you show that you meet one of the exceptions set forth in our regulations.

Form HA-83 (01-20
Representativ

- I will ask you and any other witnesses questions that will help me make a decision in your case.
- We will make an audio recording of the hearing.

The Decision

After the hearing, I will issue a written decision and mail it to you. The decision will explain my findings of fact and conclusions of law. I will base my decision on all the evidence of record, including the testimony at your hearing.

Suspect National Benefits Agency Fraud?

Please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at 1-800-999-3000 (TTY 1-866-999-3001).

If You Have Any Questions

If you have any questions, please call, (877) 888-7000, or write this office. For your convenience, our address is on the first page of this notice.

Sincerely,

Arthur Pendragon Administrative Law Judge

Enclosures: Form HA-504-OP1 (Acknowledgement of Receipt of Notice of Hearing)

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 Main Street Suite 201 Anytown, CA 90210

Back to top Form HA-83 (01-2022) Representative 13 of 14: 11B: Hearing Notice - 507

National Benefits Agency Form Approved
OMB NO. 0960-0671

ACKNOWLEDGEMENT OF RECEIPT (NOTICE OF HEARING)

(COMPLETE THIS FORM AND RETURN IT AT ONCE IN THE ENVELOPE PROVIDED. NO POSTAGE IS NECESSARY)

Claimant: Arthur Miller **Social Security Number:**
Wage Earner:

Claimant: Arthur Miller	**Social Security Number:**
	Administrative Law Judge: Arthur Pendragon
Hearing Scheduled: Tuesday, June 18, 2024 at 11:00 AM Central (CT)	Hearing Office: CITYVILLE
Location of Hearing: Telephone	

RQID:NBAQZ98765432109876543210 SITE:Y99 DR:T SSN: DOCTYPE:9876 RF:E CS:123

(Check only one)

[] I will be available by phone at the time shown on the Notice of Hearing. If an emergency arises after I mail this form and I am not available, I will immediately notify you at the telephone number shown on the Notice of Hearing.

[] I cannot be present at the time shown on the Notice of Hearing. I request that you reschedule my hearing because:

NOTE: YOUR REQUEST FOR HEARING MAY BE DISMISSED IF YOU DO NOT ATTEND THE HEARING AND CANNOT GIVE A GOOD REASON FOR NOT ATTENDING. THE TIME OR PLACE OF THE HEARING WILL BE CHANGED IF YOU HAVE A GOOD REASON FOR YOUR REQUEST.

Signature: Date: Area Code and Telephone Number:

[] I have recently moved. My new address is:

Form HA-504-OP1 (09-2003) ef (03-2015) 14 of 14: 11B: Hearing Notice - 507

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide

to acknowledge you will appear at your hearing with an Administrative Law Judge.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.nationalbenefitsagency.gov or at your local National Benefits Agency office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form HA-504-OP1 (09-2003) ef (03-2015)

Back to top

National Benefits Agency (NBA)

ACKNOWLEDGEMENT OF RECEIPT (NOTICE OF HEARING) (COMPLETE THIS FORM AND RETURN IT AT ONCE IN THE ENVELOPE PROVIDED. NO POSTAGE IS NECESSARY)

Claimant: Arthur Miller	**National Benefits Number:**
Wage Earner:	Administrative Law Judge: Arthur Pendragon
Hearing Scheduled: Wednesday, May 29, 2024 at 10:30 AM Eastern (ET)	Hearing Office: Cityville
Location of Hearing: Telephone	Barcode RQID:NBAS9876543210987654 SITE:Y78 DR:9 NBN:456-12-XXXX DOCTYPE:3005 RF:D CS:a9b9

(Check only one)

[ ] I will be available by phone at the time shown on the Notice of Hearing. If an emergency arises after I mail this form and I am not available, I will immediately notify you at the telephone number shown on the Notice of Hearing.

[ ] I cannot be present at the time shown on the Notice of Hearing. I request that you reschedule my hearing because:

NOTE: YOUR REQUEST FOR HEARING MAY BE DISMISSED IF YOU DO NOT ATTEND THE HEARING AND CANNOT GIVE A GOOD REASON FOR NOT ATTENDING. THE TIME OR PLACE OF THE HEARING WILL BE CHANGED IF YOU HAVE A GOOD REASON FOR YOUR REQUEST.

Signature: Signature of Arthur K Miller	**Date: 02-9-24**	**Area Code and Telephone Number:**
Arthur K Miller		

[ ] I have recently moved. My new address is:

Form HA-504-OP1 (09-2003) ef (03-2015) 2 of 6: 12B: Acknowledge Notice of Hearing - 504

Back to top **I**

3 of 6: 12B: Acknowledge Notice of Hearing - 504

012403050002018

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the National Benefits Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you will appear at your hearing with an Administrative Law Judge.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our System of Records Notice 99-9999, entitled Benefit Case Management System. Additional information about this and other system of records notices and our programs are available online at www.nationalbenefitsagency.gov or at your local National Benefits Agency office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

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 (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form HA-504-OP1 (09-2003) ef (03-2015) 4 of 6: 12B: Acknowledge Notice of Hearing - 504

Back to top

Personal Information

original:

Name: Arthur Miller Date of Birth: 05/21/1965 Address: 789 Oak Ave, Chicago, IL 60601-1001 Phone Number: (773) 555-9876 Email: arthur.miller.claim@fakemail.net Social Security Number: 456-12-7890 Gender: Male Place of Birth: Chicago, Illinois U.S. Citizen: Yes Currently married: Yes Prior marriages: Yes (1) Have any children: Yes Child's Name: Emily Miller Claim Number: 456-12-7890 Case Number: 987654 BNC#: AD12WE45G67890J Other Identifier: C-987654321 Member ID: 0123456789-9876543210

replace:

Name: Arthur Miller Date of Birth: 05/21/1965 Address: 789 Oak Ave, Chicago, IL 60601-1001 Phone Number: (773) 555-9876 Email: arthur.miller.claim@fakemail.net Social Security Number: 456-12-7890 Gender: Male Place of Birth: Chicago, Illinois U.S. Citizen: Yes Currently married: Yes Prior marriages: Yes (1) Have any children: Yes Child's Name: Emily Miller Claim

Number: 456-12-7890 Case Number: 987654 BNC#: AD12WE45G67890J Other Identifier: C-987654321

Member ID: 0123456789-9876543210

Service Provider Information

original:

Name: Legal Advocates for the Disabled / Walker & Associates PC (Eleanor R. Walker) Name Variations: Legal Advocates for the Disabled, Walker, Thompson & Peterson, P.C., WALKER ASSOCIATES PC, LAW OFFICES LEGAL ADVOCATES FOR THE DISABLED WALKER, THOMPSON & PETERSON, P.C. Associated Person: Eleanor R Walker / Eleanor Rose Walker / Eleanor Walker / Attorney Eleanor R. Walker Address: 1789 Main Street, Suite 201, Anytown, CA 90210 Phone Number: (310) 555-0189 (Also listed: 310-555-0234) Fax Number: (310) 555-0190 EIN: 88-7776655 Rep ID: ZQA9W8ERTG Relationship to Person Applying: Attorney Representative / Appointed Representative

replace:

Name: Legal Advocates for the Disabled / Walker & Associates PC (Eleanor R. Walker) Name Variations: Legal Advocates for the Disabled, Walker, Thompson & Peterson, P.C., WALKER ASSOCIATES PC, LAW OFFICES LEGAL ADVOCATES FOR THE DISABLED WALKER, THOMPSON & PETERSON, P.C. Associated Person: Eleanor R Walker / Eleanor Rose Walker / Eleanor Walker / Attorney Eleanor R. Walker Address: 1789 Main Street, Suite 201, Anytown, CA 90210 Phone Number: (310) 555-0189 (Also listed: 310-555-0234) Fax Number: (310) 555-0190 EIN: 88-7776655 Rep ID: ZQA9W8ERTG

Relationship to Person Applying: Attorney Representative / Appointed Representative

original:

Name: National Benefits Agency (NBA) / Appeals Division Address (Main): 1 Central Square, Capital City, DC 20001 Address (Metropolis Field Office): Suite 100, 450 Riverfront Ave, Metropolis, MI 48201 Address (Cityville Appeals Office): Unit B,

777 Suburban Way, Cityville, MI 48009 Address (Appeals Mailing): P.O. Box 5000, New Town, KY 40701-0001 Address (Texoma Records Processing Unit): Floor 3, 99 Downtown Blvd, Texoma, TX 75001-1234 / PO Box 5001, New Town, KY 40701-0002 Address (General Mail): PO Box 5002, New Town, KY 40701-0003 Phone Number (General): 1-800-555-0100 Phone Number (TTY): 1-800-555-0101 Phone Number (Metropolis Field Office): (888) 999-1234 / 888-999-1235 Phone Number (Cityville Appeals Office): (877) 888-7000 Phone Number (Texoma RPU HelpDesk): 877-555-2000 Phone Number (Fraud Hotline): (800) 999-3000 / 1-800-999-3000 (TTY 1-866-999-3001) Fax Number (Cityville Appeals Office): (833) 555-4000 Fax Number (Appeals Mailing): (877) 555-4001 Fax Number (Texoma RPU Records): 1-877-555-4002 Email (Secure Transmissions): secure-transmissions@nba.gov Website (General): www.nationalbenefitsagency.gov / http://secure.nba.gov Website (Fraud): http://inspector-general.nba.gov/report-fraud Other: Secure Transmissions Help Desk: 1-866-555-5000

replace:

Name: National Benefits Agency (NBA) / Appeals Division Address (Main): 1 Central Square, Capital City, DC 20001 Address (Metropolis Field Office): Suite 100, 450 Riverfront Ave, Metropolis, MI 48201 Address (Cityville Appeals Office): Unit B, 777 Suburban Way, Cityville, MI 48009 Address (Appeals Mailing): P.O. Box 5000, New Town, KY 40701-0001 Address (Texoma Records Processing Unit): Floor 3, 99 Downtown Blvd, Texoma, TX 75001-1234 / PO Box 5001, New Town, KY 40701-0002 Address (General Mail): PO Box 5002, New Town, KY 40701-0003 Phone Number (General): 1-800-555-0100 Phone Number (TTY): 1-800-555-0101 Phone Number (Metropolis Field Office): (888) 999-1234 / 888-999-1235 Phone Number (Cityville Appeals Office): (877) 888-7000 Phone Number (Texoma RPU HelpDesk): 877-555-2000 Phone Number (Fraud Hotline): (800) 999-3000 / 1-800-999-3000 (TTY 1-866-999-3001) Fax Number (Cityville Appeals Office): (833) 555-4000 Fax Number (Appeals Mailing): (877) 555-4001 Fax Number (Texoma RPU Records): 1-877-555-4002 Email (Secure Transmissions): secure-transmissions@nba.gov Website (General): www.nationalbenefitsagency.gov / http://secure.nba.gov Website (Fraud): http://inspector-general.nba.gov/report-fraud

Other: Secure Transmissions Help Desk: 1-866-555-5000

original:

Name: Metro Health & Wellness Center Name Variations: METRO HEALTH & WELLNESS #1, METRO HEALTH & WELLNESS #2, METRO WELLNESS CLINIC, METRO HEALTH CLINIC, METROWELLNESS GRAND RAPIDS, CLINIC - CENTRAL, METRO HEALTH & WELLNESS, Metro Wellness Office Address (Grand Rapids - Division Ave): 5900 Division Ave S, Ste 120, Grand Rapids MI 49548 Address (Grand Rapids - Wealthy St): 1000 Wealthy St SE, 2nd Fl, Grand Rapids MI 49506 (Zip also listed as 49519 - potential typo) Address (Wyoming): Wyoming, MI (Associated with phone 616-555-7890) Phone Number: 1-888-555-9876 / (616) 555-7890 / 1-616-555-7890 / (616) 456-1234 Fax Number: (616) 456-5000 Associated Providers: Amelia Chen MD-Resident, David S Green MD, Fatima Khan MD, Kevin M Jones PA-C, Sarah Rodriguez MA, Ben Carter DO-Resident, Emily R White NP, Thomas Lee MD, Jessica Brown OTR/L, Michael Davis PT, Olivia Garcia LCSW

replace:

Name: Metro Health & Wellness Center Name Variations: METRO HEALTH & WELLNESS #1, METRO HEALTH & WELLNESS #2, METRO WELLNESS CLINIC, METRO HEALTH CLINIC, METROWELLNESS GRAND RAPIDS, CLINIC - CENTRAL, METRO HEALTH & WELLNESS, Metro Wellness Office Address (Grand Rapids - Division Ave): 5900 Division Ave S, Ste 120, Grand Rapids MI 49548 Address (Grand Rapids - Wealthy St): 1000 Wealthy St SE, 2nd Fl, Grand Rapids MI 49506 (Zip also listed as 49519 - potential typo) Address (Wyoming): Wyoming, MI (Associated with phone 616-555-7890) Phone Number: 1-888-555-9876 / (616) 555-7890 / 1-616-555-7890 / (616) 456-1234 Fax Number: (616) 456-5000

Associated Providers: Amelia Chen MD-Resident, David S Green MD, Fatima Khan MD, Kevin M Jones PA-C, Sarah Rodriguez MA, Ben Carter DO-Resident, Emily R White NP, Thomas Lee MD, Jessica Brown OTR/L, Michael Davis PT, Olivia Garcia LCSW

original:

Name: Willow Creek Medical Center Address: 789 Oak Street, Springfield, IL 62704 Phone Number: (217) 555-7890 Fax Number: (217) 555-7891 Associated Providers: Dr. Eleanor Vance MD, Dr. Benjamin Carter MD-Resident, Dr. Sophia Chen MD, Nurse Rodriguez RN, Mr. Thomas Evans, Dr. Ahmed Khan MD, Nurse Olivia Green RN, Dr. Isabella Rossi MD, Mr. Michael Lee, Nurse Emily Adams CNP, Dr. Jacob Miller MD-Resident, Mrs. Patricia White PA-C, Dr. David Kim MD, Dr. Chloe Taylor DO-Resident, Dr. Noah Wilson MD, Nurse Grace Foster RN, Mr. Christopher Brown RN, Nurse Ashley Clark RN, Nurse Sarah Harris RN, Ms. Jessica Baker PCA, Mr. Kevin Martinez PT, Nurse Victoria King RN, Mr. Daniel Scott OTR/L, Dr. Samuel Davis MD Other: Affiliated with Central Illinois Health System

replace:

Name: Willow Creek Medical Center Address: 789 Oak Street, Springfield, IL 62704 Phone Number: (217) 555-7890 Fax Number: (217) 555-7891 Associated Providers: Dr. Eleanor Vance MD, Dr. Benjamin Carter MD-Resident, Dr. Sophia Chen MD, Nurse Rodriguez RN, Mr. Thomas Evans, Dr. Ahmed Khan MD, Nurse Olivia Green RN, Dr. Isabella Rossi MD, Mr. Michael Lee, Nurse Emily Adams CNP, Dr. Jacob Miller MD-Resident, Mrs. Patricia White PA-C, Dr. David Kim MD, Dr. Chloe Taylor DO-Resident, Dr. Noah Wilson MD, Nurse Grace Foster RN, Mr. Christopher Brown RN, Nurse Ashley Clark RN, Nurse Sarah Harris RN, Ms. Jessica Baker PCA, Mr. Kevin Martinez PT, Nurse Victoria King RN, Mr. Daniel Scott OTR/L, Dr. Samuel Davis MD

Other: Affiliated with Central Illinois Health System

original:

Name: Unity Care Clinic Associated Provider: Elena Petrova, MD Phone Number (Elena Petrova): +1-415-555-0187 Fax Number (Elena Petrova): +1-415-555-0188

replace:

Name: Unity Care Clinic Associated Provider: Elena Petrova, MD Phone Number (Elena Petrova): +1-415-555-0187

Fax Number (Elena Petrova): +1-415-555-0188

original:

Name: Central Plains Medical Center / Prairie General Hospital Address: 789 Oak Avenue, Omaha NE 68102 Phone Number: (402) 555-1212 / 402-555-1234 (Prairie General) Fax Number: 402-555-5678 Associated Providers: Eleanor Rigby MD, Silas Marner MD, Ebenezer Scrooge MD, Jane Eyre RN, Pip Great Expectations, Elizabeth Bennet CNP, Holden Caulfield MD-Resident, Atticus Finch PA-C, Jay Gatsby MD, Daisy Buchanan RN, Scarlett O'Hara RN, Rhett Butler PCA, Humbert Humbert MD, Katniss Everdeen DO-Resident, Harry Potter MD, Hermione Granger RN, Ron Weasley RN, Neville Longbottom RN, Luna Lovegood, Percy Jackson PT, Annabeth Chase OTR/L, Grover Underwood RN Tax ID: 987654321 (Central Plains)

replace:

Name: Central Plains Medical Center / Prairie General Hospital Address: 789 Oak Avenue, Omaha NE 68102 Phone Number: (402) 555-1212 / 402-555-1234 (Prairie General) Fax Number: 402-555-5678 Associated Providers: Eleanor Rigby MD, Silas Marner MD, Ebenezer Scrooge MD, Jane Eyre RN, Pip Great Expectations, Elizabeth Bennet CNP, Holden Caulfield MD-Resident, Atticus Finch PA-C, Jay Gatsby MD, Daisy Buchanan RN, Scarlett O'Hara RN, Rhett Butler PCA, Humbert Humbert MD, Katniss Everdeen DO-Resident, Harry Potter MD, Hermione Granger RN, Ron Weasley RN, Neville Longbottom RN, Luna Lovegood, Percy Jackson PT, Annabeth Chase OTR/L, Grover Underwood RN

Tax ID: 987654321 (Central Plains)

original:

Name: Sterling Health Clinic Name Variations: Sterling Health, Sterling Clinic, Sterling Health Clinic - Central, Sterling Health Clinic PLLC Address (Central): 456 Oak Avenue, Columbus, OH 43215 Address (North): 789 Pine Street, Worthington, OH 43085 Address (South): 101 Maple Lane, Grove City, OH 43123 Phone Number (Central): (614) 555-0101 / 1-614-555-0102 Phone Number (North): (614) 555-0202 Phone Number (South): (614) 555-0303 / (614) 555-0304 Fax Number (Central): (614) 555-0199 / 6145550198 Fax Number (South): (614) 555-0399 Associated Providers: Dr. Eleanor Vance MD, Robert Chen PA-C, Sarah Miller LCSW, Dr. Javier Rodriguez MD, Dr. Chloe Kim DO Other: Associated with Aurora Labs, Greenway Pharmacy, Summit Medical Technologies

replace:

Name: Sterling Health Clinic Name Variations: Sterling Health, Sterling Clinic, Sterling Health Clinic - Central, Sterling Health Clinic PLLC Address (Central): 456 Oak Avenue, Columbus, OH 43215 Address (North): 789 Pine Street, Worthington, OH 43085 Address (South): 101 Maple Lane, Grove City, OH 43123 Phone Number (Central): (614) 555-0101 / 1-614-555-0102 Phone Number (North): (614) 555-0202 Phone Number (South): (614) 555-0303 / (614) 555-0304 Fax Number (Central): (614) 555-0199 / 6145550198 Fax Number (South): (614) 555-0399 Associated Providers: Dr. Eleanor Vance MD, Robert Chen PA-C, Sarah Miller LCSW, Dr. Javier Rodriguez MD, Dr. Chloe Kim DO

Other: Associated with Aurora Labs, Greenway Pharmacy, Summit Medical Technologies

original:

Name: Dr. Elias Vance / Vance Medical Group Address (City Center): 456 Elm Street, Suite 300, Metroville, CA 90210 Address (Suburban Clinic): 789 Oak Avenue, Clinic B, Greenfield, CA 90215 Phone Number (City Center): (310) 555-1234 Phone Number (Suburban Clinic): (310) 555-5678 Fax Number (City Center): (310) 555-9012 Specialty: Family Medicine Tax ID: 471234567 Role: Treating Physician / Primary Care

replace:

Name: Dr. Elias Vance / Vance Medical Group Address (City Center): 456 Elm Street, Suite 300, Metroville, CA 90210 Address (Suburban Clinic): 789 Oak Avenue, Clinic B, Greenfield, CA 90215 Phone Number (City Center): (310) 555-1234 Phone Number (Suburban Clinic): (310) 555-5678 Fax Number (City Center): (310) 555-9012 Specialty: Family Medicine Tax ID: 471234567

Role: Treating Physician / Primary Care

original:

Name: Dr. Emily Carter, MD / EMILY CARTER PEDIATRICS PLLC Address: Maplewood Medical Center, 789 Oak Ave, Suite 201, Springfield, IL 62704 Phone Number: (217) 555-1234 / 217-555-5678

replace:

Name: Dr. Emily Carter, MD / EMILY CARTER PEDIATRICS PLLC Address: Maplewood Medical Center, 789 Oak Ave, Suite 201, Springfield, IL 62704

Phone Number: (217) 555-1234 / 217-555-5678

original:

Name: Dr. Eleanor Vance (No specific contact details provided besides name variation)

replace:

Name: Dr. Eleanor Vance

(No specific contact details provided besides name variation)

original:

Name: Dr. Elara Vance / Elara Vance, Ph.D. (No specific contact details provided besides name variation)

replace:

Name: Dr. Elara Vance / Elara Vance, Ph.D.

(No specific contact details provided besides name variation)

original:

Name: WELLNESS CONSULTANTS LTD (No specific contact details provided)

replace:

Name: WELLNESS CONSULTANTS LTD

(No specific contact details provided)

original:

Name: Anya Sharma MD (No specific contact details provided)

replace:

Name: Anya Sharma MD

(No specific contact details provided)

original:

Name: Christopher Thorne PhD (No specific contact details provided)

replace:

Name: Christopher Thorne PhD

(No specific contact details provided)

original:

Name: RIVER CITY HEALTH CLINIC (No specific contact details provided)

replace:

Name: RIVER CITY HEALTH CLINIC

(No specific contact details provided)

original:

Name: MediRecords Solutions Inc. Address: PO Box 12345, Dallas, TX 75212 Phone Number: 1-888-555-7890 Email: support@medirecordssolutions.com Tax ID: 86-7530911

replace:

Name: MediRecords Solutions Inc. Address: PO Box 12345, Dallas, TX 75212 Phone Number: 1-888-555-7890 Email: support@medirecordssolutions.com

Tax ID: 86-7530911

original:

Name: Community Support Integrity Unit Phone Number: (888) 777-8888 / 1-888-777-8888 Phone Number (TTY): (800) 444-5555 / 1-800-444-5555 Website: https://www.communitysupportwatch.org

replace:

Name: Community Support Integrity Unit Phone Number: (888) 777-8888 / 1-888-777-8888 Phone Number (TTY): (800) 444-5555 / 1-800-444-5555

Website: https://www.communitysupportwatch.org

original:

Name: Arthur Pendragon Phone Number: (800) 555-0199 (Associated with Avalon Benefits Department)

replace:

Name: Arthur Pendragon

Phone Number: (800) 555-0199 (Associated with Avalon Benefits Department)

original:

Name: GREAT LAKES FINANCIAL SERVICES (No specific contact details provided)

replace:

Name: GREAT LAKES FINANCIAL SERVICES

(No specific contact details provided)

original:

Name: Caring Hands Assistance Group Address: 456 Maple Ln, Serenity Creek, CA 90210

replace:

Name: Caring Hands Assistance Group

Address: 456 Maple Ln, Serenity Creek, CA 90210

original:

Name: BRIGHT STAR COMMUNITY SERVICES Address: 1420 E 48th St, Chicago, IL 60615

replace:

Name: BRIGHT STAR COMMUNITY SERVICES

Address: 1420 E 48th St, Chicago, IL 60615

original:

Name: Community Support Services LLC Address: 456 Oak Avenue, Suite 201, Anytown, CA 90210

replace:

Name: Community Support Services LLC

Address: 456 Oak Avenue, Suite 201, Anytown, CA 90210

original:

Name: Zenith Solutions Group Inc. Address: CHICAGO, IL 60602

replace:

Name: Zenith Solutions Group Inc.

Address: CHICAGO, IL 60602

original:

Name: GLOBAL IMPORTS LTD. Address: CHICAGO, IL 60601

replace:

Name: GLOBAL IMPORTS LTD.

Address: CHICAGO, IL 60601

original:

Name: Dr. Elias Müller (Berlin Heart Clinic listing) Address: Kaiser-Wilhelm-Allee 10, 12103 Berlin, Germany Phone Number: +49 30 12345678 Other ID: DE9876543210 (Listed under Berlin Heart Clinic)

replace:

Name: Dr. Elias Müller (Berlin Heart Clinic listing) Address: Kaiser-Wilhelm-Allee 10, 12103 Berlin, Germany Phone Number: +49 30 12345678

Other ID: DE9876543210 (Listed under Berlin Heart Clinic)

original:

Name: Maria Rodriguez / MARIA RODRIGUEZ Associated with: Summit Community Services (Denver, Colorado)

replace:

Name: Maria Rodriguez / MARIA RODRIGUEZ

Associated with: Summit Community Services (Denver, Colorado)

original:

Name: Community Outreach Center of America Address: Chicago, Illinois

replace:

Name: Community Outreach Center of America

Address: Chicago, Illinois

original:

Name: Compassionate Care Support Services Address: 123 Wellness Way, Detroit, Michigan

replace:

Name: Compassionate Care Support Services

Address: 123 Wellness Way, Detroit, Michigan

original:

Name: Wellness Solutions Group Address: Phoenix, Arizona

replace:

Name: Wellness Solutions Group

Address: Phoenix, Arizona

original:

Name: Alliance Care Services Address: 789 Compass Way, Northwood, Ohio

replace:

Name: Alliance Care Services

Address: 789 Compass Way, Northwood, Ohio

original:

Service Provider Information

Name: Community Support Services Inc. Address: 456 Oak Avenue, Suite 201, Atlanta, GA

replace:

Service Provider Information

Name: Community Support Services Inc.

Address: 456 Oak Avenue, Suite 201, Atlanta, GA

original:

Name: Benevolent Aid Services Address: 789 Welfare Ave, Communityville, CA 90210

replace:

Name: Benevolent Aid Services

Address: 789 Welfare Ave, Communityville, CA 90210

original:

Name: Zenith Assurance Group Address: 100 Horizon Drive, Suite 500, Cityville, ST 98765

replace:

Name: Zenith Assurance Group

Address: 100 Horizon Drive, Suite 500, Cityville, ST 98765

original:

Name: Alliance Wellness Solutions Address: Oak Brook, IL

replace:

Name: Alliance Wellness Solutions

Address: Oak Brook, IL

original:

Name: Anya Sharma, NP / ANYA S SHARMA NP / ANYA N SHARMA NP Phone Number: 555-123-4567 (listed under Metro Health Clinic) Associated with: City General Hospital, Metro Health & Wellness Center

replace:

Name: Anya Sharma, NP / ANYA S SHARMA NP / ANYA N SHARMA NP Phone Number: 555-123-4567 (listed under Metro Health Clinic)

Associated with: City General Hospital, Metro Health & Wellness Center

original:

Name: Dr. Alistair Finch / Alistair Finch MD Role: Lead Physician / Neurologist Associated with: Maplewood General Hospital, Northwood Neuroscience Center, City Memorial Clinic

replace:

Name: Dr. Alistair Finch / Alistair Finch MD Role: Lead Physician / Neurologist

Associated with: Maplewood General Hospital, Northwood Neuroscience Center, City Memorial Clinic

original:

Name: David Lee, LSW / LEE, DAVID LSW Associated with: Community Support Services, Family Wellness Center

replace:

Name: David Lee, LSW / LEE, DAVID LSW

Associated with: Community Support Services, Family Wellness Center

original:

Name: Sarah Jenkins RN / SARAH JENKINS RN Associated with: City General Hospital, Metro Health Center

replace:

Name: Sarah Jenkins RN / SARAH JENKINS RN

Associated with: City General Hospital, Metro Health Center

original:

Name: Seraphina Dubois / SERAPHINA DUBOIS Associated with: Saint Jude's Wellness Clinic

replace:

Name: Seraphina Dubois / SERAPHINA DUBOIS

Associated with: Saint Jude's Wellness Clinic

original:

Name: Dr. Anya Sharma, PhD, LCSW Associated with: Serenity Mental Wellness Clinic

replace:

Name: Dr. Anya Sharma, PhD, LCSW

Associated with: Serenity Mental Wellness Clinic

original:

Name: Arthur Ford RN / FORD RN, ARTHUR Associated with: Evergreen General Hospital, Riverwood Medical Center

replace:

Name: Arthur Ford RN / FORD RN, ARTHUR

Associated with: Evergreen General Hospital, Riverwood Medical Center

original:

Name: Dr. Elara Vance Phone Number: 555-0101 Associated with: New Leaf Wellness Clinic

replace:

Name: Dr. Elara Vance Phone Number: 555-0101

Associated with: New Leaf Wellness Clinic

original:

Name: Clara Bennett / BENNETT, CLARA Associated with: St. Jude's Medical Center, Community Health Clinic of Eastside

replace:

Name: Clara Bennett / BENNETT, CLARA

Associated with: St. Jude's Medical Center, Community Health Clinic of Eastside

original:

Name: Eleanor Vance, NP Phone Number: Ext. 4321 Associated with: City General Medical Center

replace:

Name: Eleanor Vance, NP Phone Number: Ext. 4321

Associated with: City General Medical Center

original:

Name: Eleanor Vance, LCSW / VANCE, ELEANOR LCSW Associated with: Havenwood Community Clinic

replace:

Name: Eleanor Vance, LCSW / VANCE, ELEANOR LCSW

Associated with: Havenwood Community Clinic

original:

Name: Dr. Evelyn Reed MD Phone Number: (555) 123-4567 Ext. 8910 Associated with: Saint Jude's Medical Center

replace:

Name: Dr. Evelyn Reed MD Phone Number: (555) 123-4567 Ext. 8910

Associated with: Saint Jude's Medical Center

original:

Name: Dr. Elias Thorne / THORNE MD-Physician, ELIAS Phone Number: Extension# 5501 Associated with: Blackwood General Hospital

replace:

Name: Dr. Elias Thorne / THORNE MD-Physician, ELIAS Phone Number: Extension# 5501

Associated with: Blackwood General Hospital

original:

Name: Dr. Liam O'Connell MD / O'CONNELL MD, LIAM / O'CONNELL Associated with: Cedar Ridge Hospital

replace:

Name: Dr. Liam O'Connell MD / O'CONNELL MD, LIAM / O'CONNELL

Associated with: Cedar Ridge Hospital

original:

Name: Dr. Elias Thorne MD / THORNE MD, ELIAS Associated with: St. Jude's Children's Research Center

replace:

Name: Dr. Elias Thorne MD / THORNE MD, ELIAS

Associated with: St. Jude's Children's Research Center

original:

Name: Anastasia Petrova RN / PETROVA RN, ANASTASIA Associated with: St. Michael's Medical Center

replace:

Name: Anastasia Petrova RN / PETROVA RN, ANASTASIA

Associated with: St. Michael's Medical Center

original:

Name: Mark Anthony Johnson RN / JOHNSON RN, MARK ANTHONY Associated with: Community Wellness Clinic

replace:

Name: Mark Anthony Johnson RN / JOHNSON RN, MARK ANTHONY

Associated with: Community Wellness Clinic

original:

Name: Sarah Johnson LCSW / JOHNSON LCSW, SARAH Associated with: Beacon Street Family Services

replace:

Name: Sarah Johnson LCSW / JOHNSON LCSW, SARAH

Associated with: Beacon Street Family Services

original:

Name: Clara Barton RN / BARTON RN,CLARA Associated with: St. Jude's Community Clinic

replace:

Name: Clara Barton RN / BARTON RN,CLARA

Associated with: St. Jude's Community Clinic

original:

Name: Alice Smith PCA Associated with: Northern Hills Medical Center

replace:

Name: Alice Smith PCA

Associated with: Northern Hills Medical Center

original:

Name: Olivia Thompson / THOMPSON, OLIVIA Associated with: Grace Mercy Community Services

replace:

Name: Olivia Thompson / THOMPSON, OLIVIA

Associated with: Grace Mercy Community Services

original:

Name: Dr. Elias Thorne Phone Number: (313) 555-9876 Associated with: Metro Wellness Clinic

replace:

Name: Dr. Elias Thorne Phone Number: (313) 555-9876

Associated with: Metro Wellness Clinic

original:

Name: Robert Miller LCSW / Miller, Robert Phone Number: 555-0123 (Office) Associated with: Community Health Clinic of Oakwood

replace:

Name: Robert Miller LCSW / Miller, Robert Phone Number: 555-0123 (Office)

Associated with: Community Health Clinic of Oakwood

original:

Name: Clara Benson RN / BENSON RN, CLARA Associated with: Mercy General Hospital

replace:

Name: Clara Benson RN / BENSON RN, CLARA

Associated with: Mercy General Hospital

original:

Name: Dr. Elias Thorne, PhD, LCSW Associated with: Willow Creek Mental Wellness Center

replace:

Name: Dr. Elias Thorne, PhD, LCSW

Associated with: Willow Creek Mental Wellness Center

original:

Name: Dr. Eleanor Vance, MD Phone Number: +1-585-241-0987 Fax Number: +1-585-365-7890 Associated with: University of Rochester Medical Center

replace:

Name: Dr. Eleanor Vance, MD Phone Number: +1-585-241-0987 Fax Number: +1-585-365-7890

Associated with: University of Rochester Medical Center

original:

Name: Dr. Sarah Miller PhD Associated with: Evergreen Health Clinic

replace:

Name: Dr. Sarah Miller PhD

Associated with: Evergreen Health Clinic

original:

Name: Sarah Miller Associated with: Evergreen Social Services

replace:

Name: Sarah Miller

Associated with: Evergreen Social Services

original:

Name: Eleanor Vance, D.O. Associated with: Willow Creek Clinic

replace:

Name: Eleanor Vance, D.O.

Associated with: Willow Creek Clinic

original:

Name: Dr. Anya Sharma, M.D. Associated with: Riverbend Health Clinic

replace:

Name: Dr. Anya Sharma, M.D.

Associated with: Riverbend Health Clinic

original:

Name: Eleanor Vance PhD / VANCE PHD, ELEANOR Associated with: Community Health Center of Hope

replace:

Name: Eleanor Vance PhD / VANCE PHD, ELEANOR

Associated with: Community Health Center of Hope

original:

Name: Community Health Clinic of Oakwood Phone Number: 734-987-6543

replace:

Name: Community Health Clinic of Oakwood

Phone Number: 734-987-6543

original:

Name: City General Hospital Address: 1500 Elmwood Avenue, Metropolis, CA 90210 Phone Number: 555-123-4567

replace:

Name: City General Hospital Address: 1500 Elmwood Avenue, Metropolis, CA 90210

Phone Number: 555-123-4567

original:

Name: Summit Peak Medical Center Phone Number: +1-720-555-0189

replace:

Name: Summit Peak Medical Center

Phone Number: +1-720-555-0189

original:

Name: Oakwood Springs Medical Center Phone Number: 734-555-0123

replace:

Name: Oakwood Springs Medical Center

Phone Number: 734-555-0123

original:

Name: Evergreen Physical Therapy & Wellness Phone Number: 503-555-0199
Other: Specializing in Post-Injury Rehabilitation

replace:

Name: Evergreen Physical Therapy & Wellness Phone Number: 503-555-0199

Other: Specializing in Post-Injury Rehabilitation

original:

Name: Community Health Clinic Phone Number: 555-123-4567

replace:

Name: Community Health Clinic

Phone Number: 555-123-4567

original:

Name: Community Wellness Center Other ID: 987654321098 (Associated with Dr. Sanjay Patel)

replace:

Name: Community Wellness Center

Other ID: 987654321098 (Associated with Dr. Sanjay Patel)

original:

Name: Community Support Advocates Address: 789 Oak Avenue, Anytown, CA 91234 Phone Number: (555) 123-4567 Email: contact@communitysupport.org

replace:

Name: Community Support Advocates Address: 789 Oak Avenue, Anytown, CA 91234 Phone Number: (555) 123-4567

Email: contact@communitysupport.org

original:

Name: Community Support Services Address: 789 Elm Street, Anytown, CA 90210 Phone Number: 5551234567

replace:

Name: Community Support Services Address: 789 Elm Street, Anytown, CA 90210

Phone Number: 5551234567

original:

Name: City Care Pharmacy Address: 101 Elm Street, Anywhere, CA 90210 Phone Number: (555) 123-4567

replace:

Name: City Care Pharmacy Address: 101 Elm Street, Anywhere, CA 90210 Phone Number: (555) 123-4567

original:

Name: Aurora Medical Plaza / Imaging Services Address: 789 Oak Avenue, Clearwater, FL 33755 Phone Number: (727) 555-9876 / (727) AURORA1 Fax Number: (727) 555-1234

replace:

Name: Aurora Medical Plaza / Imaging Services Address: 789 Oak Avenue, Clearwater, FL 33755 Phone Number: (727) 555-9876 / (727) AURORA1

Fax Number: (727) 555-1234

original:

Name: Compassionate Care Connect (Client Management System, no specific contact details)

replace:

Name: Compassionate Care Connect

(Client Management System, no specific contact details)

original:

Name: GENESIS DIAGNOSTICS Address: 789 Oak Avenue, Suite B, Rivertown, CA 90210 Phone Number: 800-111-2222

replace:

Name: GENESIS DIAGNOSTICS Address: 789 Oak Avenue, Suite B, Rivertown, CA 90210

Phone Number: 800-111-2222

original:

Name: Compassionate Care Alliance / Gentle Hands Services Address (Main): 555 Serenity Lane, Suite 100, Harmony Creek, CA 90210 Address (Mail): P.O. Box 789, Harmony Creek, CA 90211 Phone Number: 800-777-8888 / 310-999-0000 Phone Number (TTY): 711 Fax Number: 310-999-0001 Email: info@gentlehands.org Website: www.gentlehands.org

replace:

Name: Compassionate Care Alliance / Gentle Hands Services Address (Main): 555 Serenity Lane, Suite 100, Harmony Creek, CA 90210 Address (Mail): P.O. Box 789, Harmony Creek, CA 90211 Phone Number: 800-777-8888 / 310-999-0000 Phone Number (TTY): 711 Fax Number: 310-999-0001 Email: info@gentlehands.org

Website: www.gentlehands.org

original:

Name: Willow Creek Health System (Associated with Unity Care Network, no specific contact details)

replace:

Name: Willow Creek Health System

(Associated with Unity Care Network, no specific contact details)

original:

Name: California Department of Social Services (CDSS) Phone Number: 1-800-952-5253 Phone Number (TTY): 1-800-952-8349

replace:

Name: California Department of Social Services (CDSS) Phone Number: 1-800-952-5253

Phone Number (TTY): 1-800-952-8349

original:

Name: Community Outreach and Support Services Alliance Address: 456 Oak Avenue, Suite 300, Anytown, CA 90210 Phone Number: (555) 123-4567

replace:

Name: Community Outreach and Support Services Alliance Address: 456 Oak Avenue, Suite 300, Anytown, CA 90210

Phone Number: (555) 123-4567

original:

Name: Community Assistance Program Associated Centers: CAP - Central Branch (246 Maple Dr, Metropolis, NY 10001), CAP - Riverside Office (789 River Rd, Metropolis, NY 10002) Associated with: Department of Human Services

replace:

Name: Community Assistance Program Associated Centers: CAP - Central Branch (246 Maple Dr, Metropolis, NY 10001), CAP - Riverside Office (789 River Rd, Metropolis, NY 10002)

Associated with: Department of Human Services

5 of 6: 12B: Acknowledge Notice of Hearing - 504 Page 5 of 5

Arthur Miller BNC#: AD12WE45G67890J 012403050002019 • I will ask you and any other witnesses questions that will help me make a decision in your case. • We will make an audio recording of the hearing.

The Decision

After the hearing, I will issue a written decision and mail it to you. The decision will explain my findings of fact and conclusions of law. I will base my decision on all the evidence of record, including the testimony at your hearing.

Suspect Social Security Fraud?

Please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at 1-800-999- 3000 (TTY 1-866-999-3001).

If You Have Any Questions

If you have any questions, please call, (800) 555-0199, or write this office. For your convenience, our address is on the first page of this notice.

Enclosures: Form HA-504-OP1 (Acknowledgement of Receipt of Notice of Hearing)

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 MAIN STREET STE 201 ANYTOWN, CA 90210

NATIONAL BENEFITS AGENCY - T2L PO Box 5002, New Town, KY 40701-0003

OFFICIAL BUSINESS PENALTY FOR PRIVATE USE, $300

ANYTOWN CA 90210 22 FEB 2024 PM 7 L

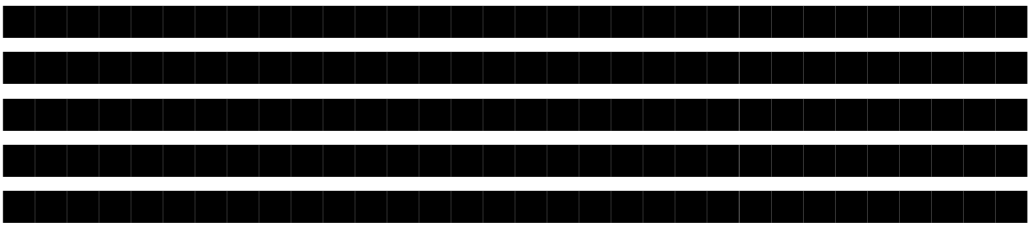
NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL FIRST-CLASS MAIL PERMIT NO. 18452 WASHINGTON D.C. POSTAGE WILL BE PAID BY NATIONAL BENEFITS AGENCY

98765432101

1 of 4: 13B: Notice Of Hearing Reminder - HA503

NATIONAL BENEFITS AGENCY Refer To: Arthur Miller BNC#: AD12WE45G67890J



Arthur Miller 789 OAK AVE CHICAGO, IL 60601

Appeals Division NBA APPEALS DIVISION UNIT B 777 SUBURBAN WAY CITYVILLE, MI 48009 Tel: (877) 888-7000 / Fax: (833) 555-4000

May 6, 2024

NOTICE OF HEARING-IMPORTANT REMINDER

We recently mailed you a Notice stating the time of the hearing you requested. We enclosed with your Notice an Acknowledgement Form, which we asked you to complete and return. If you have not yet returned the Acknowledgement Form, please call the number listed above and tell us if you plan to come to your hearing. If you do not plan to come to your hearing, please tell us why you cannot come.

We expect you to be present at the hearing scheduled for:

Day: Wednesday Date: May 29, 2024 Time: 10:30 AM Eastern (ET)

An administrative law judge (ALJ) will conduct your hearing by telephone. On the date and at the time listed above, the ALJ will call you at the telephone number in our file. The number is (773) 555-9876. If this is not the correct telephone number, please call this office immediately.

On the day of the hearing, we will call you at the telephone number you provided: If you provided a cell phone number for the hearing, the incoming call will display as “Capital City, DC.” If you provided a landline phone number, your caller ID will display as “NBA U.S. Govt.”

If you do not attend the hearing, the ALJ may dismiss your request for hearing, without further notice, unless he or she finds that you have a good reason for not attending.

See Next Page

Form HA-L503 (01-2022) Claimant 2 of 4: 13B: Notice Of Hearing Reminder - HA503

Arthur Miller BNC#: AD12WE45G67890J Page 2 of 2

If you do not understand this notice, or if some unexpected problem arises, please call this office at (877) 888-7000.

Sincerely,

National Benefits Agency

Enclosures: Form HA-L503 (Notice of Hearing)

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 Main Street STE 201 ANYTOWN, CA 90210

Form HA-L503 (01-2022) Claimant 3 of 4: 13B: Notice Of Hearing Reminder - NBA-L503

NATIONAL BENEFITS AGENCY NATIONAL BENEFITS AGENCY | Refer To: Arthur Miller | Appeals Division | | BNC#: AD12WE45G67890J | NBA APPEALS OFFICE | | [Barcode Placeholder] | Unit B | | | 777 SUBURBAN WAY | | | CITYVILLE, MI 48009 | | | Tel: (877) 888-7000 / Fax: (833) 555-4000 | | | May 6, 2024 |

Arthur Miller 789 Oak Ave Chicago, IL 60601

NOTICE OF HEARING-IMPORTANT REMINDER

We recently mailed you a Notice stating the time of the hearing you requested. We enclosed with your Notice an Acknowledgement Form, which we asked you to complete and return. If you have not yet returned the Acknowledgement Form, please call the number listed above and tell us if you plan to come to your hearing. If you do not plan to come to your hearing, please tell us why you cannot come.

We expect you to be present at the hearing scheduled for:

Day: Wednesday Date: May 29, 2024 Time: 10:30 AM Eastern (ET)

An administrative law judge (ALJ) will conduct your hearing by telephone. On the date and at the time listed above, the ALJ will call you at the telephone number in

our file. The number is (773) 555-9876. If this is not the correct telephone number, please call this office immediately.

On the day of the hearing, we will call you at the telephone number you provided: If you provided a cell phone number for the hearing, the incoming call will display as "Anytown, CA." If you provided a landline phone number, your caller ID will display as "NBA U.S Govt."

If you do not attend the hearing, the ALJ may dismiss your request for hearing, without further notice, unless he or she finds that you have a good reason for not attending.

See Next Page

Form NBA-L503 (0
Repre

4 of 4: 13B: Notice Of Hearing Reminder - NB-AD-F101

If you do not understand this notice, or if some unexpected problem arises, please call this hearing office at (877) 888-7000.

Enclosures: Form NB-AD-F101 (Notice of Hearing)

Sincerely,

National B

cc: Eleanor Rose Walker WALKER ASSOCIATES PC 1789 Main Street Suite 201 Anytown, CA 90210

For
Rep

HEARING FORMAT ELECTION STATEMENT

Claimant Name: Arthur Miller Claimant SSN: 456-12-7890

The undersigned appointed representative has consulted with the above-referenced claimant, and both the claimant and the representative provide this statement.

This hearing format election statement replaces all prior statements on this issue. If documents received in this claim create ambiguity or concern, please contact the representative prior to scheduling a hearing.

Consent to Online Video Hearing (OVH) (using Microsoft Teams)

- [ ] We consent to an online video hearing (OVH) (using Microsoft Teams) and agree to appear in that manner.

Claimant's Email Address (if different from representative's email address) (for possible OVH)	**Representative's Email Address (for possible OVH)**

Consent to Telephone

- [x] We consent to a telephone hearing and agree to appear in that manner.

Claimant's Number (for possible telephone hearing)	**Representative's Number (for possible telephone hearing)**
(773) 555-9876	310-555-0234

In-Person Only

- [ ] We do not consent to a telephone hearing. We do not consent to an online video hearing (OVH). We ask for an in-person hearing

Objection to Video Teleconference (VTC) (video at an SSA location)

- [x] We object to appearing for a hearing by video teleconference (VTC) (video at an SSA location). The claimant has the right to object to appearing by VTC within 30 days of receiving the acknowledgement of the request for hearing.
    - [x] The claimant has timely objected to VTC (through this submission or a previous notification).
    - [ ] The claimant did not timely object to VTC but has good cause for the late submission, which is:

No Preference

- [ ] We have no preference as to hearing format. Please schedule the hearing in any manner: telephone, OVH, VTC, or in-person

Signed: __ Attorney Eleanor R. Walker

Dated: _5/20/24_

Form NOSSCR-2023-HFES-2

1 of 3: 1D: Lead Protective Filing Worksheet - LPFWKSHT

ICLM SUMMARY 456-12-7890 JULY 14, 2022 THIRD PARTY UNSIGNED APPLICATION Your information was received on July 14, 2022 at 3:07:36 PM.

Identification

Applicant Identification Name: Arthur Miller Social Security Number: --7890 Date of Birth: May 21, 1965 Gender: Male Blind or low vision: No Disabled: Yes Start Date of Disability: August 15, 2023 Denied Benefits in Last 60 days: No Diagnosed with condition that is expected to end in death: No

Preparer's Contact Information Name: Eleanor R Walker Relationship to Applicant: Attorney Representative Organization Name: Legal Advocates for the Disabled Address: 1789 Main Street, Suite 201, Anytown, CA, 90210 Phone: (310) 555-0189

Applicant's Contact Information

Contact Information Mailing Address: 789 Oak Ave, Chicago, Illinois, 60601 Reside at this address: Yes Phone: (773) 555-9876 Mobile Best time to call: Anytime between 9 a.m. and 5 p.m.

Ability to Communicate in English Speak English: Yes Read English: Yes Write English: Yes

Language Preferences Preferred language for speaking: English Preferred language for reading: English

Birth and Citizenship Information Place of Birth: Chicago, Illinois U.S. Citizen: Yes Type of Citizenship: US citizen born inside US

Other Social Security Numbers and Names

Other Social Security Numbers Any other Social Security Numbers used: No

Other Names Any other names used: No

General

Marriage Information Currently married: Yes

Prior Marriages Any prior marriages: Yes (1)

Back to top 2 of 3: 1D: Lead Protective Filing Worksheet - LPFWKSHT

Children Have any children: Yes Any children who became disabled prior to age 22: Yes Any unmarried children under age 18: No Any unmarried children aged 18 to 19 still attending elementary or secondary school (below college level) full time: No Child 1: Emily Miller More than 10 children: No

Military Details Military service prior to 1968: No

Employer Details Worked for an employer in 2021: No Worked or will work for an employer in 2022: No

Self-Employment Details Self-employed in 2021: No Self-employed in 2022: No

Supplemental Information Worked outside the US: No Agree with earnings history as shown on Social Security statement: Not sure or Arthur Miller does not have a statement

Total Earnings Neither working for an employer nor self-employed in 2021 or later, last year worked: 2020

Other Pensions/Annuities Ever work in a job where U.S. Social Security taxes were not deducted or withheld: No

Direct Deposit Details Own or co-own a bank account to use for Direct Deposit: No

Other Benefits Benefit Information Intend to apply for Supplemental Security Income benefits: Yes Any previous application(s) for Medicare, Social Security, or Supplemental Security Income benefits: No

Ability To Work Illnesses, injuries, conditions related to work: No Now able to work: No

Disability Payments Filed or intend to file for workers' compensation or other public disability benefits: No Received money from employer on/after date unable to work: No Expect to receive money from employer in the future: No

Dependents Has one parent who receives one-half support: No

Remarks & Options Remarks The following are your remarks: Arthur Miller will contact NBA to Discuss 3 of 3: 1D: Lead Protective Filing Worksheet - LPFWKSHT

```
applying for SSI. Please forward a BARCODE to our office so we
updated medical records. Thank you
```

Back to top

My Responsibilities

I agree to notify National Benefits Agency promptly if I (or anyone for whom I receive benefits)

- become employed or self-employed while outside the U.S.,
- change citizenship, or
- go (for 30 days or more) to any country other than the residence address shown on this application.

I agree to return any payments that are not due.

I declare under penalty of perjury that I have examined all the information on this application and it is true and correct to the best of my knowledge.

Signature: Arthur Miller Date: 07-27-2022

Witnesses are required only if this application has been signed by mark (x) above. If signed by (x), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

Signature of Witness Signature of Witness ---------- ----------

Number and Street Address Number and Street Address ---------- ----------

City, State and ZIP Code City, State and ZIP Code ---------- ----------

This form should be submitted to the address shown on your notice.

1234C567X890123 FAKEFILENAME.TXT 999888777 12345678901234567890123456789O

Back to top 2 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG Page 12 of 13 456000890

Privacy Act Statement

Collection and Use of Personal Information

Sections 202(a), 205(a), 1631(e) and 1872 of the National Benefits Agency 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 an accurate and timely decision on any claim filed and could result in the loss of some benefits.

We will use the information to make a determination of eligibility for benefits for you and your dependents. 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 payee applicants;
3. To a National Benefits Agency beneficiary or claimant when a claim is filed by another individual on the same record which is adverse to the beneficiary, but only information concerning the facts relevant to the interests of each party in a claim; and
4. 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) 60-0059, entitled Earnings Recording and Self-Employment Income System; 60-0089, entitled Claims Folders Systems; 60-0090, entitled Master Beneficiary Record; 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.nationalbenefitsagency.gov/foia/bluebook.

Paperwork Reduction Act Statement

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. sec. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to review, confirm or sign this application summary unless we display a valid Office of Management and Budget control number; the control number is 0960-0618. We estimate that it will take about 20

minutes to read the instructions, review the information contained in the summary, and sign the application. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top Miller Oak Ave National Benefits Agency Suite 100 450 Riverfront Ave METROPOLIS MI 48201

Back to top 4 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG

National Benefits Agency

Retirement, Survivors and Disability Insurance

Important Information

NATIONAL BENEFITS AGENCY Suite 100 450 Riverfront Ave Metropolis, MI 48201

Date: July 21, 2022 Claim Number: 456-12-7890

ARTHUR MILLER 789 Oak Ave Chicago, IL 60601-1001 יני

Telephone: (888) 999-1234 Confirmation Number: 53242697

An internet application for National Benefits Agency benefits was completed for you by ELEANOR R WALKER of LEGAL ADVOCATES FOR THE DISABLED on July 14, 2022. We stored the information in our records. We are sending the application to you for your review and signature.

If you are blind or visually impaired, you may choose to receive your notices or other communications in a special format. Please visit our website at www.nationalbenefitsagency.gov/notices to designate a special notice option.

If you do not want these benefits, you do not need to contact us. We will not take any action unless we receive your signed application.

What You Need To Do To Apply For Benefits

Review all the entries on the enclosed Internet Application Summary and confirm that the information is correct.

Correct any information that is wrong and write your initials next to it.

Sign and date the Internet Application Summary in the space shown as, "Signature."

NOTE: It is important that you sign the application, not the person who filled it in for you or anyone else.

Read, complete and sign the enclosed SSA-8240 (Authorization for The National Benefits Agency to Obtain Wage and employment Information from Payroll Data Providers).

See Next Page SSA-L2 (9/2008)

- Gather the documents shown on the enclosed List of Acceptable Evidence Documents. We will return all documents and photocopies to you unless you tell us you don't want them.
- If you decide to continue applying for disability, complete the form SSA-827 (Authorization to Disclose Information to the National Benefits Agency) as shown below:
    1. Read the entire form SSA-827, front and back.
    2. Write your name and Social Security Number in the upper right corner of the form.
    3. Sign the form in the space shown as "INDIVIDUAL authorizing disclosure".
    4. Enter your address and daytime phone number in the spaces shown for them.
    5. Date the form in the space shown as "Date Signed".
    6. Do not fill in the large empty box in the middle of the form, put a check in the empty block under "PURPOSE", or complete any other sections of the form.
    7. Have a witness sign and provide his or her address or phone number in the space shown on the form. If you sign with an "X", have a second witness sign and provide his or her address.
- Mail or bring the following items to your local Social Security office:
    1. All pages of the signed "Internet Application Summary",
    2. Any documents requested on the "List of Acceptable Evidence Documents",
    3. The signed Medical Release form (SSA-827), and

4. The completed and signed Authorization for The National Benefits Agency to Obtain Wage and Employment Information from Payroll Data Providers Form (SSA-8240).

- If you mail them, please follow the mailing instructions on the last page of this letter. Remember to add your return address and correct postage to the envelope provided. If you prefer to give us these documents in person, the office location is shown under "If You Have Questions."
- If you do not want to apply for disability, you do not need to return the SSA-827 with your retirement application.

What Happens Next

Once we receive your signed application, we will decide if you can get benefits. The sooner we receive it, the sooner we can decide.

SSA-L2 (9/2008) 6 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG Page 3 of 13 456-12-7890

We may use July 14, 2022 as the official date of your application for National Benefits Agency benefits. In order to use July 14, 2022, we must receive the signed application by January 23, 2023 or you may lose National Benefits Agency benefits.

If you intend to apply for Community Support benefit payments, you will need to file a separate application for Community Support benefits. We may use July 14, 2022 as the official date of your Community Support application. In order to use July 14, 2022 we must receive a signed application by September 19, 2022 or you may lose Community Support benefit payments. Please contact us to arrange an appointment to apply for Community Support.

Community Support or CSP is a federal program that provides monthly payments to people who have limited income and assets and who are age 65 or older, or blind, or have a disability. For more information about the CSP program, please read the pamphlet, "You May Be Able To Get Community Support (CSP)."

If any of the dates shown above fall on a weekend or federal holiday, we must receive the signed application by the following business day.

Check Your Application

You can check the status of your application on the Internet or using our automated telephone application.

To check the status of your application on the Internet:

1. Just go to the "National Benefits Agency Online" homepage at www.nationalbenefitsagency.gov.
2. Select my National Benefits Agency account and either sign into your account or create a new account.

To check the status of your application using our automated telephone application:

1. Call us at 1-800-555-0100.
2. At the Main Menu, say "Claim Status" or "Application Status" when asked about the reason for your call.
3. Follow the prompts to check your application status. You will need to enter your Confirmation Number located at the top of this letter.

Please guard your Confirmation Number carefully. It is the key to your application information. National Benefits Agency employees will never ask for your Confirmation Number.

Disability claims take longer to process than other types of National Benefits Agency claims. It takes time to obtain sufficient medical evidence to show that you are disabled. It may take 90-120 days before your application status will show a final decision on your disability claim.

Your Reporting Responsibilities

It is important that you let us know as soon as possible whenever one of the changes listed below occurs. You need to contact us if:

you change your mailing address; your citizenship or immigration status changes; or your Medicare Part B premium is automatically paid from an account at a bank or other financial institution, and you change institutions or close the account.

You can call, write, or visit our office or our website at www.nationalbenefitsagency.gov/pgm/reach.htm to make a report. Please have your Social Security number handy when you contact us.

Other government agencies may provide us with information you give to them, but you must also report any changes to us.

Supplemental Nutrition Assistance Program (SNAP)

If you meet certain conditions, SNAP benefits may be available to help you buy food. For more information about SNAP benefits, read Supplemental Nutrition Assistance Program Facts at www.nationalbenefitsagency.gov/pubs/EN-05-10101.pdf on the Internet.

If you want to file for SNAP benefits now, you can:

Apply at any local SNAP office. Apply online at www.fns.usda.gov/snap/apply on the Internet. Apply by mail. First, download and complete your state form at www.fns.usda.gov/snap/snap-application-and-local-office-locators on the Internet. Then, mail the form to your local SNAP office.

Additional Information

If you want to get in touch with the person who completed your application, the address is: 1789 MAIN STREET, SUITE 201, ANYTOWN, CA 90210. The telephone number is (310) 555-0189.

If You Have Questions

If you have questions, call, write, or visit any National Benefits Agency office and have this letter with you. The telephone number and mailing address of the office processing your claim are shown at the top of this letter.

NBA-Form (09/2008) 8 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG Page 5 of 13 456-12-7890

You can also reach us at 1-800-555-0100 (TTY 1-800-555-0101). We can answer most questions over the phone. The office is located at:

NATIONAL BENEFITS AGENCY
Suite 100
450 Riverfront Ave
Metropolis MI 48201

Suspect National Benefits Agency Fraud?

If you suspect National Benefits Agency fraud, please visit http://inspector-general.nba.gov/report-fraud or call the Community Support Integrity Unit at 1-800-999-3000 (TTY 1-866-999-3001).

National Benefits Agency

Enclosure(s):

- Return Envelope
- Pub 05-11069
- Internet Application Summary
- List of Acceptable Evidence Documents
- Medical Release (SSA-827)
- Authorization to Obtain Wage and Employment Information from Payroll Data Providers (SSA-8240)

07032897W001267 NOTAFP.X3.PBISBNOT.ISB.R220714.PAM 111010000 00036100 106356761 987654321606011001789 !

Back to top SSA-L2 (9/2008) 9 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG 33009280 Page of B

List of Acceptable Evidence Documents

You need to send us the documents shown below. Send all documents you have with your signed application. We will help you get the other documents. You should not delay sending your application if you don't have all the documents. You may lose benefits if you delay.

NOTE: Include your Social Security Number when you mail documents to us. We need this to match the documents to your application. Please write your Social Security Number on a separate sheet of paper and include it in the envelope with your documents. Do not write anything on your original documents. You may bring the documents to any National Benefits Agency office if you don't want to mail them. They will be examined and returned to you.

CAUTION: Don't mail foreign birth records or any Department of Border Integrity (DBI) documents to us - especially those you are required to keep with you at all times. These documents are extremely difficult, time-consuming, and expensive to

replace if lost. Some cannot be replaced. Instead, bring them to any National Benefits Agency office where they will be examined and returned to you.

Medical Evidence

We will ask for your medical documents if you have received treatment for your alleged disability. This includes copies or photocopies of medical records, doctors' reports, and recent test results. Your treatment records are used along with other information to see if you meet our definition of disability.

We need information about your medical treatment for any illnesses, injuries, or conditions that limit your ability to work. We will not need to request copies of medical documents from your doctors, hospitals, clinics, or other medical sources if you already have them. We can process your application faster with this information. Do not delay filing your application if you do not have these documents. We will ask the medical sources you list to send them to us. We may ask you to go to a special examination at our expense if you have not received treatment, or we do not obtain enough documents about your condition(s).

We also ask for information such as: What are your illnesses, injuries, or conditions? When did they begin? How do they limit your activities? What did medical tests show? What treatment did you receive?

In addition, we ask for information about your ability to do work-related activities, such as walking, sitting, lifting, carrying, and understanding and remembering instructions.

We do not ask your doctors to decide if you are disabled.

We can accept uncertified photocopies of your medical documents.

Back to top 10 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG

Internet Application Summary

This form summarizes all the information the person who started an Internet application for National Benefits on your behalf provided to us.

We received your benefits application on July 14, 2022 at 03:07:36 PM.

Instructions

1. Review all the entries and confirm that the information is correct.
2. Write your initials next to any corrections that you make.
3. Sign and date the Internet Application Summary in the space shown as, "Signature." NOTE: It is important that you sign the application, not the person who filled it in for you or anyone else.
4. Mail or bring all pages of the signed Internet Application Summary and any other documents you need to your local National Benefits Agency office. If you mail them, please follow the mailing instructions on the last page of this letter. Remember to add your return address and the correct postage to the envelope provided.
5. If you prefer to give us these documents in person, the office location is shown under "If You Have Questions" at the end of the letter.

The following section of text is provided in the language it was submitted.

Application Summary

I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors, and Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Benefits Act, as presently amended.

Identification

Applicant Identification

Name: Arthur Miller Social Security Number: --7890 Date of Birth: May 21, 1965 Gender: Male Blind or low vision: No Disabled: Yes Start Date of Disability: July 1, 2022 Denied Benefits in Last 60 days: No Diagnosed with condition that is expected to end in death: No 11 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG

456.127890 Page 8 of 13

Preparer's Contact Information Name: Eleanor R Walker Relationship to Applicant: Attorney Representative Organization Name: Legal Advocates for the Disabled Address: 1789 Main Street, Suite 201, Anytown, CA 90210 Phone: (310) 555-0189

Applicant's Contact Information

Contact Information Mailing Address: 789 Oak Ave, Chicago, Illinois, 60601 Reside at this address: Yes Phone: (773) 555-9876 Mobile Best time to call: Anytime between 9 a.m. and 5 p.m.

Ability to Communicate in English Speak English: Yes Read English: Yes Write English: Yes

Language Preferences Preferred language for speaking: English Preferred language for reading: English

Birth and Citizenship Information Place of Birth: Chicago, Illinois U.S. Citizen: Yes Type of Citizenship: US citizen born inside US

Other Social Security Numbers and Names

Other Social Security Numbers Any other Social Security Numbers used: No

Other Names Any other names used: No

General

Marriage Information Currently married: Yes

Prior Marriages Any prior marriages: Yes (1)

Children Have any children: Yes Any children who became disabled prior to age 22: Yes Any unmarried children under age 18: No Any unmarried children aged 18 to 19 still attending elementary or secondary school (below college level) full time: No Child 1: Emily Miller More than 10 children: No

Back to top 12 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG

456-12-7890 Page 9 of 13

Military Details Military service prior to 1968: No

Employer Details Worked for an employer in 2021: No Worked or will work for an employer in 2022: No

Self-Employment Details Self-employed in 2021: No Self-employed in 2022: No

Supplemental Information Worked outside the US: No Agree with earnings history as shown on Social Security statement: Not sure or Arthur Miller does not have a statement

Total Earnings Neither working for an employer nor self-employed in 2021 or later, last year worked: 2020

Other Pensions/Annuities Ever work in a job where U.S. Social Security taxes were not deducted or withheld: No

Direct Deposit Details Own or co-own a bank account to use for Direct Deposit: No

Other Benefits

Benefit Information Intend to apply for Supplemental Security Income benefits: Yes Any previous application(s) for Medicare, Social Security, or Supplemental Security Income benefits: No

Ability To Work Illnesses, injuries, conditions related to work: No Now able to work: No

Disability Payments Filed or intend to file for workers' compensation or other public disability benefits: No Received money from employer on/after date unable to work: No Expect to receive money from employer in the future: No

Dependents Has one parent who receives one-half support: No

Remarks & Options

Remarks The following are your remarks: Arthur Miller will contact NBA to Discuss applying for SSI. Please forward a BARCODE to our office so we can submit updated medical records. Thank you

Back to top 13 of 13: 2D: Internet: Third-Party Filers Wet Signature Page - 3RDPTYWETSIG

456-12-7890 Page 10 of 13

Back to top

National Benefits Agency

Supplemental Security Income

ARTHUR MILLER NATIONAL BENEFITS AGENCY 789 OAK AVE Suite 100 CHICAGO, IL 60601 450 Riverfront Ave Metropolis, MI 48201 Date: August 15, 2022 BNC#: XXYYZZ11223344A

Time: 10:34 AM ET
Unit: MCMDIB

Application Summary for Supplemental Security Income

On August 15, 2022, you applied for Supplemental Security Income and any federally administered State supplementation under title XVI of the Social Security Act, for benefits under the other programs administered by the National Benefits Agency, and where applicable, for medical assistance under title XIX of the Social Security Act. We have stored your application electronically in our records.

What You Need To Do

Review this summary to ensure we recorded your statements correctly. If you agree with all your statements, you should keep this summary for your records. If you disagree with any of your statements, you should contact us within 10 days after receiving this summary to let us know.

Identification

My name is ARTHUR MILLER. My National Benefits Agency claim number is 456-12-7890.

My date of birth is May 21, 1965.

I have not used any other National Benefits Agency claim number(s).

I am not blind.

I am disabled. My disability began on July 1, 2022.

See Next Page

Back to top 2 of 7: 3D: Application for Supplemental Security Income Benefits - 8000

I am a United States citizen by birth. I never lived outside the United States. I never was married.

Fugitive Felon Information The following statements describe my fugitive felon status as of August 15, 2022. I have been accused or convicted of a felony or an attempt to commit a felony in the state of Illinois. From: August 15, 2022 To: continuing I do not have a felony or arrest warrant for escape from custody, flight to avoid prosecution or confinement, or flight-escape.

Living Arrangements The following statements describe my living arrangements as of August 1, 2022. I began living at 789 Oak Ave, Chicago, IL 60601-1001 on August 15, 1982. I live in a house/apartment/mobile home/houseboat. I do not expect these arrangements to change.

Resources This report of resources is valid for any and all SSI claims in which I am involved. I own the following from August 1, 2022 to continuing: Checking account: Financial institution name: GREAT LAKES FINANCIAL SERVICES Value: $0.00 From: August 2022 To: continuing I do not own any other type of resource.

Income This report of income is valid for any and all SSI claims in which I am involved. 3 of 7: 3D: Application for Supplemental Security Income Benefits - 8000

I do not receive any other type of income.

Eligibility for Other Benefits

I do not currently get Supplemental Nutrition Assistance Program (SNAP) benefits.

Medicaid

You may be eligible for Medicaid. However, you must help your State identify other sources that may pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who are your legal responsibility. This includes information to help the State determine who a child's father is.

If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid agency.

Medical Assistance

I agree that any payments from sources responsible for paying for medical care will go to the State if Medicaid already has paid for this care.

I do not have any private, group or government health insurance that pays the cost of my medical care.

Permission to Contact Financial Institutions for ARTHUR MILLER

We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, or (3) your eligibility for SSI terminates. If you do not give or cancel your permission, you will not be eligible for SSI and we will deny your claim or stop your payments.

I give National Benefits Agency permission to contact any financial institution and request any financial records that financial institution may have about me. 4 of 7: 3D: Application for Community Support Services - 8000

Important Reminder

Penalty of Perjury

You declared under penalty of perjury that all the information on this summary is true and correct to the best of your knowledge. Anyone who knowingly gives a false or misleading statement about a material fact in an application, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

Important Information--Please Read Carefully

We will check your statements and compare our records with records from other State and Federal agencies, including the Internal Revenue Service to make sure you are paid the correct amount.

If you have a question or something to report, call 888-999-1235 and ask for MS. DAVIS. If you call or visit our office, please have this summary with you. For general information about the National Benefits Agency, visit our web site at www.nationalbenefitsagency.gov on the Internet.

You may visit or write to the National Benefits Agency Office at:

NATIONAL BENEFITS AGENCY Suite 100 450 Riverfront Ave Metropolis MI 48201

We will process this application for Community Support Benefits as quickly as possible. You should hear from us within 90 to 120 days. If you do not hear from us by then, please get in touch with us.

We will let you know if we need more information to decide if you are eligible for benefits payments. In the meantime, if you move or change your mailing address, you--or someone for you-- should report the change to the office shown.

Also, you (or someone for you) must let us know if you are admitted to a hospital or other medical facility. You could lose some benefits payments if you do not let us know right away.

Always give the agency claim number when writing or telephoning about this claim. If you have any questions about this claim, we will be glad to help you. 5 of

Helpful Health Care Websites

Health Information

The Community Support and Welfare Department provides information on many health topics at www.WellnessInfoHub.org on the Internet. You may wish to visit that site to review that information, which may be helpful to you.

Prescription Drug Assistance Programs

You may be able to get help paying for prescription drugs. To find out what programs are offered by drug companies, state and local governments, and local organizations, please visit www.WellnessInfoHub.org/medhelp on the Internet.

Back to top 6 of 7: 3D: Application for Supplemental Security Income Benefits - 8000 08/15/2022

Privacy Act Statement

Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. The information you provide us will be used to enable the National Benefits Agency to determine if you are eligible for Supplemental Security Income (SSI) payments.

The information you furnish on this form is voluntary. However, failure to provide the requested information may keep us from making an accurate and timely decision on your claim, which in turn may result in loss of some payments.

We rarely use the information you supply for any purpose other than for determining eligibility for SSI. However, we may use it for the administration and integrity of National Benefits Agency programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist National Benefits Agency in establishing rights to National Benefits Agency benefits and/or coverage;

2. To comply with Federal Laws requiring the release of information from National Benefits Agency records (e.g., to the Government Accountability Office and Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of National Benefits Agency programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Complete lists of routine uses for this information are available in System of Records Notice 60-0103, Supplemental Security Income Record and Special Veterans Benefits, and also in System of Records Notice 60-0089, Claims Folder Systems. The Notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.nationalbenefitsagency.gov or at your local National Benefits Agency office.

Back to top

22S2864J75464 08/15/2022

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 18-19 minutes to read the instructions, gather the facts, and answer the questions. Send or bring the Completed Form to Your Local National Benefits Agency Office. The office is listed under U.S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top

1 of 3: 4D: Certified Earnings Records - CERTERN

NH NAME ARTHUR	**MILLER**	**SN:456-12-7890 PG 001+**
INPUT 02/26/24	DO:X54 UNIT:CN DERO MOD:10	
RUN DATE 02/26/24 V:04/11/23		
CONTROL 456-12-7890		

EVENT ICERS EARNINGS RECORD TID CERTIFIED EARNINGS RECORD ALERTS NH HAS 01 YOC'S FOR NONCOVERED PENSION PIA PRIOR CLAIM DATA DOES NOT EXIST ON DRAMS POSSIBLE GAPS 1992 1993 1994 1999 2004 2005 2006 2010 POSSIBLE GAPS 2011 2012 2013 2014 2018 2019 POSSIBLE DUPLICATES 1995 2016 2020 POSSIBLE INCOMPLETES 1990 2017 NH HAS 01 DIS EX YOC'S FOR NONCOVERED PENSION PIA

INFORMTNL DISABILITY NON-EXCLUSION 20/40 INSURED TEST MET DISABILITY EXCLUSION FULLY INSURED STATUS MET DISABLED NH IS FULLY INSURED RIB DISABILITY NON-EXCLUSION FULLY INSURED STATUS MET DISABILITY EXCLUSION 20/40 INSURED TEST MET PRIOR CLAIM STATUS - A

ID INFO	**REQ NAME:MILLER**	**REQ SEX:M**	**REQ DATE OF BIRTH:05/21/1965**
DATES	FILING DATE:07/14/22	DATE OF ONSET:07/01/2022	

DIB INPUT MBR/INPUT DATA ONSET:02/15/2013 DENIAL/DISALLOWANCE:90 ONSET:07/01/2022 DENIAL/DISALLOWANCE:90

INS STAT DISABILITY: EXCL REQ QC:29 EXCL HAS:040 NON-EXCL REQ QC:29 NON-EXCL HAS:040 DIS DLI:12/25 OTHER: FIRST INSURED:01/22

TOT COV SSA QC 1937 THRU 1950 QC: 0 WAGE QC AFTER 1946: 59 WAGE QC AFTER 1950: 59 SE QC:NONE AG QC:NONE

TOT EARN SSA TOT AFTER 1936: 131100.65 TOT AFTER 1950: 131100.65

COMPUTATIONAL YEARLY EARNINGS

MAX	**AMT**	**YR**	**QC**	**REGULAR**	**U**	**NH**	**INDEXED**	**RAILROAD**	**RQSM**	**DMW**	**SE**	**AG**
48000	500	89	CCCN	1965.72		H	5440.43					
51300	520	90	NNNF	132.33		H	350.07					
53400	540	91	CNNN	716.13		H	1826.43					

MAX	AMT	YR	QC	REGULAR	U	NH INDEXED	RAILROAD	RQSM	DMW	SE	AG
55500	570	92	NNNN								

Back to top 2 of 3: 4D: Certified Earnings Records - CERTERN

57600 590 93 NNNN 60600 620 94 NNNN 61200 630 95 CCCC 3923.59 H 8834.57
62700 640 96 CCNN 1308.25 H 2808.38 65400 670 97 CNNN 1264.35 H 2564.50
68400 700 98 CCCN 2713.50 H 5230.10 72600 740 99 NNNN

NH NAME ARTHUR MILLER SN:456-12-7890 PG 002 INPUT 02/26/24 DO:X54
UNIT:CN DERO MOD:10

COMPUTATIONAL YEARLY EARNINGS

MAX	AMT	YR	QC	REGULAR	U	NH INDEXED	RAILROAD	RQSM	DMW	SE	AG
76200	780	00	CCCC	4474.81	H	7741.53					
80400	830	01	CCCC	15125.52	H	25557.79					
84900	870	02	CCCC	15473.11	H	25885.51					
87000	890	03	CCCC	7281.75	H	11891.21					
87900	900	04	NNNN								
90000	920	05	NNNN								
94200	970	06	NNNN								
97500	1000	07	CCCC	5390.68	H	7421.67					
102000	1050	08	CNNN	1605.98	H	2161.33					
106800	1090	09	CNNN	1711.40	H	2338.47					
	1120	10	NNNN								
	1120	11	NNNN								
110100	1130	12	NNNN		L						
113700	1160	13	NNNN		L						
117000	1200	14	NNNN		H						
118500	1220	15	CCCN	4326.55	H	5003.88					
	1260	16	CCCC	10166.76	H	11627.01					
127200	1300	17	CCCC	5449.50	H	6024.18					

Back to top 3 of 3: 4D: Certified Earnings Records - CERTERN

128400 1320 18 NNNN H 132900 1360 19 NNNN H 137700 1410 20 CCCC 23104.19 H 23104.19 142800 1470 21 CCCC 11185.53 H 11185.53 147000 1510 22 CCCC 13781.00 13781.00 Y 160200 1640 23 NNNN 168600 1730 24 NNNN

COMP DATA DI - COMP TYPE:NS 78 DIS EX AIME: $579.00 EFF DATE:12/22 PIA: $566.40 PIFC:L FAM MAX: $566.40 START BASE YEAR/START DATE:1951 LAST BASE YEAR/CLOSE DATE:2021 DIVIDEND: $166996.78 DM:288 DOY:5 YOC: I/Y: ELG YR:2022

DI - COMP TYPE:NS 78R DIS EX AIME: $627.00 EFF DATE:01/23 PIA: $613.30 PIFC:L FAM MAX: $613.30 EFF DATE:12/23 PIA: $632.90 PIFC:L FAM MAX: $632.90 START BASE YEAR/START DATE:1951 LAST BASE YEAR/CLOSE DATE:2022 DIVIDEND: $180777.78 DM:288 DOY:5 YOC: I/Y: ELG YR:2022

TRIAL COMPUTATIONS: NS 78 $584.50 NS 78R $632.90

1 of 2: 5D: Summary Earnings Query - SEQY

Identifying Client Information

SSN: 456-12-7890 Name: Arthur Miller DOB: 05/21/1965 Sex: Male

---

SUMMARY OF FICA EARNINGS

Year	Total Earnings
1989	1965.72
1990	132.33
1991	716.13
1992	0.00
1993	0.00
1994	0.00
1995	3923.59
1996	1308.25
1997	1264.35
1998	2713.50
1999	0.00
2000	4474.81
2001	15125.52
2002	15473.11
2003	7281.75
2004	0.00
2005	0.00
2006	0.00
2007	5390.68
2008	1605.98
2009	1711.40
2010	0.00
2011	0.00
2012	0.00
2013	0.00

Year	Total Earnings
2014	0.00
2015	4326.55
2016	10166.76
2017	5449.50
2018	0.00
2019	0.00
2020	23104.19
2021	11185.53
2022	13781.00
2023	0.00

SUMMARY OF MQGE EARNINGS

Year	Total Earnings
1983	0.00
1984	0.00
1985	0.00
1986	0.00
1987	0.00
1988	0.00
1989	0.00
1990	881.60
1991	0.00
1992	0.00
1993	0.00
1994	0.00
1995	0.00
1996	0.00
1997	0.00
1998	0.00
1999	0.00
2000	0.00
2001	0.00
2002	0.00

Year	Total Earnings
2003	0.00
2004	0.00
2005	0.00
2006	0.00
2007	0.00
2008	0.00
2009	0.00
2010	0.00
2011	0.00
2012	0.00
2013	0.00
2014	0.00
2015	0.00
2016	0.00
2017	0.00
2018	0.00
2019	0.00
2020	0.00
2021	0.00
2022	0.00
2023	0.00

REMARKS

Non-Covered earnings present for: 1986

Back to top 2 of 2: 5D: Summary Earnings Query - SEQY

Back to top

Identifying Information

SSN: 456-12-7890 Name: Arthur Miller

Requested: 2007 - 2024 DOB: 05/21/1965 Sex: Male Years

2007 Earning Details

2007 Covered

Employer Identification Number (EIN:) 383423022 Employer Name and Address: Caring Hands Assistance Group, 456 Maple Ln, Serenity Creek, CA 90210

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
A MILLER	5390.68	5390.68	8116-AY-56249	00	A	A		5390.68

2007 Wage Totals/Types Total Earnings

Wage Total 5390.68

2007 Employer Total 5390.68

2007 Non-Covered

No Non-Covered Earnings for this year.

2007 Yearly Total 5390.68

2008 Earning Details

2008 Covered

Employer Identification Number (EIN:) 383423022 Employer Name and Address: Caring Hands Assistance Group, 456 Maple Ln, Serenity Creek, CA 90210

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensat
A MILLER	1605.98	1605.98	9072-BH-76011	00	A	A		1605.98

2008 Wage Totals/Types	Total Earnings
Wage Total	1605.98

2008 Employer Total 1605.98

Back to top

2 of 9: 6D: Detailed Earnings Query - DEQY

2008 Non-Covered

No Non-Covered Earnings for this year.

2008 Yearly Total 1605.98

2009 Earning Details

2009 Covered

Employer Identification Number (EIN:) 383296327 Employer Name and Address: BRIGHT STAR COMMUNITY SERVICES, % JOHN G POTTS PRESIDENT, 1420 E 48th St, Chicago, IL 60615

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
A MILLER	1711.40	1711.40	0091-AP-61807	00	A	A		1711.40

2009 Wage Totals/Types	Total Earnings
Wage Total	1711.40

2009 Employer Total 1711.40

2009 Non-Covered

No Non-Covered Earnings for this year.

2009 Yearly Total 1711.40

2010 Earning Details

2010 Covered

No Covered Earnings for this year.

2010 Non-Covered

No Non-Covered Earnings for this year.

Back to top 3 of 9: 6D: Detailed Earnings Query - DEQY

2011 Earning Details

2011 Covered

No Covered Earnings for this year.

2011 Non-Covered

No Non-Covered Earnings for this year.

2012 Earning Details

2012 Covered

No Covered Earnings for this year.

2012 Non-Covered

No Non-Covered Earnings for this year.

2013 Earning Details

2013 Covered

No Covered Earnings for this year.

2013 Non-Covered

No Non-Covered Earnings for this year.

2014 Earning Details

2014 Covered

No Covered Earnings for this year.

2014 Non-Covered

No Non-Covered Earnings for this year.

Back to top 4 of 9: 6D: Detailed Earnings Query - DEQY

No Non-Covered Earnings for this year.

2015 Earning Details

2015 Covered

Employer Identification Number (EIN:) 98-7654321 Employer Name and Address: Community Support Services LLC, 456 Oak Avenue, Suite 201, Anytown, CA 90210

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
Arthur Miller	4326.55	4326.55	9876-AB-12345	00	A	A		4326.55

2015 Wage Totals/Types Total Earnings

Wage Total	4326.55

2015 Employer Total 4326.55

2015 Non-Covered

No Non-Covered Earnings for this year.

2015 Yearly Total 4326.55

2016 Earning Details

2016 Covered

Employer Identification Number (EIN:) 98-7654321 Employer Name and Address: Community Support Services LLC, 456 Oak Avenue, Suite 201, Anytown, CA 90210

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
Arthur Miller	10166.76	10166.76	5432-XY-67890	00	A	A		10166.76

2016 Wage Totals/Types	Total Earnings
Wage Total	10166.76

2016 Employer Total 10166.76

5 of 9: 6D: Detailed Earnings Query - DEQY

2016 Non-Covered

No Non-Covered Earnings for this year.

2016 Yearly Total 10166.76

2017 Earning Details

2017 Covered

Employer Identification Number (EIN:) 99-8887766 Employer Name and Address: Riverbend Distributors, Anytown, CA 90210

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
A M MILLER	1237.50	1237.50	8029-CK-21737	00	A	A		1237.50
2017 Wage Totals/ Types	Total Earnings							
---	---							
Wage Total	1237.50							
2017 Employer Total	1237.50							
---	---							

Employer Identification Number (EIN:) 99-8887765 Employer Name and Address: Community Support Services LLC, 456 Oak Avenue, Suite 201, Anytown, CA 90210

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensat
A M MILLER	4212.00	4212.00	8026-HR-41798	00	A	A		4212.00
2017 Wage Totals/ Types	Total Earnings							
---	---							
Wage Total	4212.00							
2017 Employer Total	4212.00							
---	---							

2017 Non-Covered

No Non-Covered Earnings for this year.

2017 Yearly Total 5449.50

2018 Earning Details

Back to top 6 of 9: 6D: Detailed Earnings Query - DEQY

2018 Covered

No Covered Earnings for this year.

2018 Non-Covered

No Non-Covered Earnings for this year.

2019 Earning Details

2019 Covered

No Covered Earnings for this year.

2019 Non-Covered

No Non-Covered Earnings for this year.

2020 Earning Details

2020 Covered

Employer Identification Number (EIN): 987654321 Employer Name and Address: CITYWIDE TRANSPORT SOLUTIONS, CHICAGO, IL 60615

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
	1525.00	1525.00		00	A	A		1525.00

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
A R MILLER			9876-AZ-12345					

2020 Wage Totals/Types	Total Earnings
Wage Total	1525.00

2020 Employer Total 1525.00

Employer Identification Number (EIN): 123456789 Employer Name and Address: Zenith Solutions Group Inc., JOHN SMITH MEMBER, CHICAGO, IL 60602

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
			9876-					

Back to top 7 of 9: 6D: Detailed Earnings Query - DEQY

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
A MILLER	21579.19	21579.19	AC-41282	00	A	A		21579.19

2020 Wage Totals/Types	Total Earnings
Wage Total	21579.19

2020 Employer Total 21579.19

2020 Non-Covered

No Non-Covered Earnings for this year.

2020 Yearly Total 23104.19

2021 Earning Details

2021 Covered

Employer Identification Number (EIN:) 98-7654321 Employer Name and Address: Zenith Solutions Group Inc., Representative, CHICAGO, IL 60602

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensat
A MILLER	9053.03	9053.03	2032-HM-29080	00	A	A		9053.03

2021 Wage Totals/Types	Total Earnings
Wage Total	9053.03

2021 Employer Total 9053.03

Employer Identification Number (EIN:) 87-6543210 Employer Name and Address: GLOBAL IMPORTS LTD., Representative, CHICAGO, IL 60601

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compensati
A MILLER	2132.50	2132.50	2027-FD-26408	00	A	A		2132.50

2021 Wage Totals/Types	Total Earnings
Wage Total	2132.50

2021 Employer Total 2132.50

Back to top 8 of 9: 6D: Detailed Earnings Query - DEQY

2021 Non-Covered

No Non-Covered Earnings for this year.

2021 Yearly Total 11185.53

2022 Earning Details

2022 Covered

Employer Identification Number (EIN:) Employer Name and Address: EMPLOYER NAME AND ADDRESS NOT ELECTRONICALLY AVAILABLE

Reported Name	Earnings	Medicare Wages	Control Number	Report Period Code	Report Type	Employment Type	Location/ Action	Total Compe
A M MILLER	13781.00	13781.00	2215-79-11674	00	O	I		0.00

2022 Wage Totals/Types	Total Earnings
OASDI Self-Employment Total	13781.00

2022 Employer Total 13781.00

2022 Non-Covered

No Non-Covered Earnings for this year.

2022 Yearly Total 13781.00

2023 Earning Details

2023 Covered

No Covered Earnings for this year.

2023 Non-Covered

No Non-Covered Earnings for this year.

2024 Earning Details

Back to top 9 of 9: 6D: Benefit Record Inquiry

2024 Reported

No Reported Income for this year.

2024 Unreported

No Unreported Income for this year.

Back to top

1 of 1: 7D: New Hire, Quarter Wage, Unemployment Query (NBA Database) - NBA Database

The following response was returned from the NBA Database service call:

> No NBA Database data found associated with the queried SSN. These results have been saved to the Secure File.

Back to top

1 of 2: 1E: Disability Report - Field Office - 3367 Src: FO 08/15/2022

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

(3367) ID/Prior Filings

Identifying Information

1. Name of person(s) on whose Social Security record(s) this claim is being filed: Arthur Miller His or Her Social Security Number(s): 456-12-7890 Name of Claimant (if different from above): SSN (if different from above): Gender: Male Date of Birth: 05/21/1965
2. Claimant's Alleged Onset Date: 07/01/2022
3. Potential Onset Date:
4. Reason for Potential Onset Date:
5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

1. Protective Filing Date: Non-Blind Date Last Insured (DIB/Freeze case): Blind Date Last Insured (DIB/Freeze case): Closed Period Case: No

Prior Filing Information

1. Prior Filing(s): Yes If "Yes" and you are not sending the prior folder, enter the following:

Type of prior claim(s):	**DIB**
SSN(s) of prior claim(s):	456-12-7890 A
Date and level of last decision:	07/29/2013 Initial
Last Decision:	Denial
Location of prior folder:	CEF
Prior folder requested:	No
Date requested:	

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

(3367) Observations

1. Observations/Perceptions: How was the Interview Conducted? No contact with claimant (Select all that apply)

   Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

(3367) Development

1. Development Initiated by FO: A. Medical: B. Other: C. Forms to be completed by applicant and sent to the DDS: NBA-3371: NBA-3369: Other:
2. Was medical evidence brought in to the FO by the claimant? No
3. Is DDS capability development needed? No Remarks:

Name of Interviewer: A. Smith Phone Number: (888) 999-1234 Name of Person Completing Form: A. Jones Date: 08/15/2022

Form NBA-3367 EDCS

Monday, August 15, 2022 10:52:30

|:----------:|:----------:|

WORK HISTORY REPORT - Form SSA-3369 Form Approved OMB No. 0960-0578

(3369) Work History Report

Section 1 - Information About The Disabled Person

A. Name (First, Middle Initial, Last)	B. Social Security Number
Arthur Miller	456-12-7890

C. Daytime Telephone Number (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.): 773-555-9876 Primary None Alternate

Section 2 - Information About Your Work

A. List all the jobs that you have had in the 15 years before you became unable to work because of your illnesses, injuries, or conditions.

Job Title	Type of Business	Dates Worked (From-To)
1. Car crusher	Towing and vehicle demolition	MAY 2019 - JUNE 2020
2. _		-
3. _		-
4. _		-

Back to top 2 of 7: 2E: Work History Report - 3369 Src: Arthur Miller 08/15/2022

Give us more information about Job No. 1. Estimate hours and pay, if you need to.

Job Title No. 1: Car crusher

Rate of Pay:	$10.00	Per:	Hour
Hours Per Day:	8	Days Per Week:	6

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.): remove wheels, battery, radiators from vehicles to prepare for demolition/crushing.

In this Job, did you: Use machines, tools, or equipment? Yes Use technical knowledge or skills? No Do any writing, complete reports, or perform duties like this? No

In this Job, how many total hours each day did you: Walk? 8 Stand? 8 Sit? 0 Climb? 8 Stoop? (Bend down and forward at waist): 8 Kneel? (Bend legs to rest on knees): 8 Crouch? (Bend legs & back down & forward): 8 Crawl? (Move on hands & knees): 0 Handle, grab or grasp big objects? 8 Reach? 8 Write, type or handle small objects? 8

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.): lift of wheels with rims, radiators and batteries. Remove and carry the pieces approx. 10ft load on tractor bucket then removed from tractor bucket and stack on shelving.

Heaviest weight you lifted: 50 lbs.

Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.): 50 lbs. or more

Did you supervise other people in this job? No How many people did you supervise? What part of your time was spent supervising people? Did you hire and fire employees? Were you a lead worker? No

Back to top 3 of 7: 2E: Work History Report - 3369 Src: Arthur Miller 08/15/2022

Give us more information about Job No. 2. Estimate hours and pay, if you need to.

Job Title No. 2:	**Per:**
Rate of Pay:	Days Per Week:
Hours Per Day:	

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.):

In this Job, did you:

- Use machines, tools, or equipment?
- Use technical knowledge or skills?
- Do any writing, complete reports, or perform duties like this?

In this Job, how many total hours each day did you:

- Walk?

- Stand?
- Sit?
- Climb?
- Stoop? (Bend down and forward at waist):
- Kneel? (Bend legs to rest on knees):
- Crouch? (Bend legs & back down & forward):
- Crawl? (Move on hands & knees):
- Handle, grab or grasp big objects?
- Reach?
- Write, type or handle small objects?

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.):

Heaviest weight you lifted:

Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.):

Did you supervise other people in this job?

- How many people did you supervise?
- What part of your time was spent supervising people?
- Did you hire and fire employees?
- Were you a lead worker?

Back to top 4 of 7: 2E: Work History Report - 3369 Src: Arthur Miller 08/15/2022

Give us more information about Job No. 3. Estimate hours and pay, if you need to.

Job Title No. 3:

Rate of Pay: Per:

Hours Per Day: Days Per Week:

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.):

In this Job, did you: Use machines, tools, or equipment? Use technical knowledge or skills? Do any writing, complete reports, or perform duties like this?

In this Job, how many total hours each day did you: Walk? Stand? Sit? Climb? Stoop? (Bend down and forward at waist): Kneel? (Bend legs to rest on knees):

Crouch? (Bend legs & back down & forward): Crawl? (Move on hands & knees): Handle, grab or grasp big objects? Reach? Write, type or handle small objects?

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.):

Heaviest weight you lifted:

Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.):

Did you supervise other people in this job? How many people did you supervise? What part of your time was spent supervising people? Did you hire and fire employees? Were you a lead worker?

Back to top

5 of 7: 2E: Work History Report - 3369 Src: Arthur Miller 08/15/2022

Give us more information about Job No. 4. Estimate hours and pay, if you need to.

Job Title No. 4:

Rate of Pay: Per:

Hours Per Day: Days Per Week:

Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.):

In this Job, did you: Use machines, tools, or equipment? Use technical knowledge or skills? Do any writing, complete reports, or perform duties like this?

In this Job, how many total hours each day did you: Walk? Stand? Sit? Climb? Stoop? (Bend down and forward at waist): Kneel? (Bend legs to rest on knees): Crouch? (Bend legs & back down & forward): Crawl? (Move on hands & knees): Handle, grab or grasp big objects? Reach? Write, type or handle small objects?

Lifting and Carrying (Explain what you lifted, how far you carried it, and how often you did this.): Heaviest weight you lifted: Weight you frequently lifted (By frequently, we mean from 1/3 to 2/3 of the workday.):

Did you supervise other people in this job? How many people did you supervise? What part of your time was spent supervising people? Did you hire and fire employees? Were you a lead worker?

(3369) Section 3 - Remarks

Back to top

6 of 7: 2E: Work History Report - 9876 Src: Arthur Miller 11/21/2023

Back to top 7 of 7: 2E: Work History Report - 3369 Src: Arthur Miller 08/15/2022

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	**Date (Month, day, year)**

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	**2. Signature of Witness**
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form SSA-3369 EDCS Monday, August 15, 2022 10:52:30

Back to top

DISABILITY REPORT - ADULT - Form SSA-3368

(3368) Section 1 - Information About the Disabled Person

1.A. Name (First, Middle Initial, Last) Arthur Miller 1.B. Social Security Number 456-12-7890 1.C. Mailing Address (Street or PO Box) Include apartment number if applicable, City, State/Province, Zip/Postal Code, Country (if not USA) 789 OAK AVE CHICAGO, IL 60601 1.D. Email Address 1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada. Phone number 773-555-9876 Check this box if you do not have a phone or number where we can leave a message 1.F. Alternate Phone Number - another number where we may reach you, if any Alternate phone number 1.G. Can you speak and understand English? Yes If no, what language do you prefer? NOTE: If you cannot speak and understand English, we will provide an interpreter, free of charge. 1.H. Can you read and understand English? Yes 1.I. Can you write more than your name in English? Yes 1.J. Have you used any other names on your medical or educational records? No Examples are maiden name, other married name or nickname. If yes, please list them here:

(3368) Section 2 - Contacts

Give the name of someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)	Sarah Peterson
2.B. Relationship to you:	Friend
2.C. Daytime Phone Number (as described in 1.E. above)	555-555-0100
2.D. Mailing Address (Street or PO Box)	789 Oak Ave
Include apartment number or unit if applicable,	Chicago, IL 60601

City, State/Province, Zip/Postal Code,
Country (if not USA)

2.E. Can this person speak and understand English? Yes

If no, what language is preferred?

Back to top 2 of 7: 3E: Disability Report - Adult - 3368 Src: Eleanor R Walker 08/15/2022

2.F. Who is completing this report? Someone else (Please complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)	Eleanor R Walker, Legal Advocates for the Disabled
2.H. Relationship to Person Applying:	Attorney Representative
2.I. Daytime Phone Number	(310) 555-0189
2.J. Mailing Address (Street or PO Box) Include apartment number or unit if applicable, City, State/Province, Zip/Postal Code, Country (if not USA)	 1789 Main Street Suite 201 Anytown, CA 90210

(3368) Section 3 - Medical Conditions

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1. Car accident in 2012
2. Chronic hip pain
3. Nerve damage related to neck area
4. Insomnia due to pain
5. Difficulty sitting and standing
6. Herniated discs in back
7. LEFT SIDE OF BODY WENT NUMB

3.B. What is your height without shoes? 5' 5" 3.C. What is your weight without shoes? 160 lbs. 3.D. Do your conditions cause you pain or other symptoms? Yes

(3368) Section 4 - Work Activity

4.A. Are you currently working? No, I have stopped working (Go to question 4.C. below)

IF YOU HAVE NEVER WORKED: 4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year)

IF YOU HAVE STOPPED WORKING: 4.C. When did you stop working? (month/day/year) 06/01/2020 Why did you stop working? Because of my condition(s). 4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours or rate of pay) No (Go to Section 5 - Education and Training)

Back to top 3 of 7: 3E: Disability Report - Adult - 3368 Src: Eleanor Walker 08/15/2022

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1350 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.) No (Go to Section 5)

IF YOU ARE CURRENTLY WORKING: 4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours) 4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1350 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

(3368) Section 5 - Education and Training Information

5.A. Check the highest grade of school completed. 12th Grade (Select 12, if you have education equivalent to high school from another country) Date Completed: 05/1983

Name of School: **Northwood High School**

City, State, Country (if not USA) Chicago, IL

5.B. Did you receive special education, such as through an Individualized Education Plan (IEP) or equivalent education? Yes Dates: from 09/1977 to 05/1983 Check the last grade of special education completed. 12th Grade Reason(s) for IEP or equivalent education: Slow learning, troubles with reading math and comprehension. School where you last received special education. If different from 5.A., complete below.

5.C. Have you completed any type of specialized job training, trade or vocational school? No

5.D.What written language do you use every day in most situations (at home, work, school, in community, etc.)? English

5.E. In the language you identified in 5.D., can you read a simple message, such as a shopping list or short and simple notes? Yes

5.F. In the language you identified in 5.D., can you write a simple message, such as a shopping list or short and simple notes? Yes

---

(3368) Section 6 - Job History

6.A. List the jobs (up to 5) that you had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

Back to top 4 of 7: 3E: Disability Report - Adult - 3368 Src: Eleanor Walker 08/15/2022

Job Title	**Type of Business**	**Dates Worked From mm/yy**	**To mm/yy**	**Hours Per Day**	**Days Per Week**	**Rate Of Pay Amount**	**Frequency**
Car crusher	Towing and vehicle demolition	MAY 2019	JUNE 2020	8	6	$10.00	Hour

Check the box below that applies to you.

[X] I had only one job in the last 15 years before I became unable to work. Answer the questions below.

Do not complete this page if you had more than one job in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day? remove wheels, battery, radiators from vehicles to prepare for demolition/crushing.

6.C. In this job, did you: Use machines, tools or equipment? Yes Use technical knowledge or skills? No Do any writing, complete reports, or perform any duties like this? No

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	**Hours**	**Task**	**Hours**
Walk	8	Stoop (Bend down & forward at the waist)	8
Stand	8	Kneel (Bend legs to rest on knees)	8
Sit	0	Crouch (Bend legs & back down & forward)	8
Climb	8	Crawl (Move on hands & knees)	0
Handle large objects	8	Write, type or handle small objects	8
Reach	8		

6.E. Lifting and carrying (Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job): lift of wheels with rims, radiators and batteries. Remove and carry the pieces approx. 10ft load on tractor bucket then removed from tractor bucket and stack on shelving.

6.F. Check heaviest weight lifted: 50 lbs.

6.G. Check weight frequently lifted (by frequently, we mean from 1/3 to 2/3 of the workday.): 50 lbs. or more

6.H. Did you supervise other people in this job? No How many people did you supervise? What part of your time did you spend supervising people? Did you hire and fire employees?

6.I. Were you a lead worker? No

(3368) Section 7 - Medicines

Back to top 5 of 7: 3E: Disability Report - Adult - 3368 Src: Eleanor R. Walker 08/15/2022

1. Are you taking any medicines (prescription or non-prescription)? No (Go to Section 8 - Medical Treatment)

Name of Medicine If prescribed, give name of doctor Reason for medicine

(3368) Section 8 - Medical Treatment

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or do you have a future appointment scheduled:

8.A. For any physical condition(s)? Yes

8.B. For any mental condition(s) (including emotional or learning problems)? No

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

Tell us who may have medical records about any of your physical and/or mental condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals (including emergency room visits), clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office

Name of health care professional who treated you	Dr. Elias Vance	
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.		
Phone Number	310-555-5678	Patient ID# (if known)
Mailing Address	789 Oak Avenue, Clinic B, Greenfield, CA 90215	

Dates of Treatment

	1. Office, Clinic or Outpatient visits	**2. Emergency Room visits List the most recent date first**	**3. Overnight hospital stays List the most recent date first**
First Visit	1/2020	A.	A. Date in

	1. Office, Clinic or Outpatient visits	2. Emergency Room visits List the most recent date first	3. Overnight hospital stays List the most recent date first	
				Date out
Last Visit	6/2020	B.	B. Date in	Date out
Next scheduled appointment (if any)		C.	C. Date in	Date out

What medical conditions were treated or evaluated? Back, neck , hip pain. Was last seen in 2020 before he stopped working. He was supposed to have and MRI done but because of facility and insurance issues he was never able to get it done.

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.) Primary care physician- Regular evaluations, medication scripts, routine testing, specialist referrals, and diagnostic testing.

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks.

Back to top 6 of 7: 3E: Disability Report - Adult - 3368 Src: Eleanor Walker 08/15/2022

Check this box if no tests by this provider or at this facility.

Kind of Test Dates of Tests

(3368) Section 9 - Other Medical Information

1. Does anyone else have medical information about any of your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.) No (If you are receiving Supplemental Security Income (SSI) and

have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11.)

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

(3368) Section 10 - Vocational Rehabilitation, Employment, or Other Support Services

10.A. Have you participated, or are you participating in: An individual work plan with an employment network under the Ticket to Work Program; An individualized plan for employment with a vocational rehabilitation agency or any other organization; A Plan to Achieve Self-Support (PASS); An individualized education program (IEP) through a school (if a student age 18 - 21); or Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

(3368) Section 11 - Remarks

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

Arthur Miller will contact NBA to Discuss applying for SSI. Please forward a BARCODE to our office so we can submit updated medical records. Thank youSEC. 7 - I WENT TO MORE THAN ONE: SPECIAL EDUCATION SCHOOL

Back to top

7 of 7: 3E: Disability Report - Adult - 3368 Src: Eleanor Walker 01/15/2023

| Date Report Completed | _ / / |

| | (Month) (Day) (Year) |

| Form SSA-3368 EDCS | Sunday, January 15, 2023 11:30:00 |

Back to top

FUNCTION REPORT – ADULT

How your illnesses, injuries, or conditions limit your activities
For SSA Use Only
Do not write in this box.

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the Social Security Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION A- GENERAL INFORMATION

---

1. NAME OF DISABLED PERSON (First, Middle, Last) | 2. SOCIAL SECURITY NUMBER ARTHUR MILLER | XXX-XX-7890

---

1. YOUR DAYTIME TELEPHONE NUMBER (If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)

773 555-9876 [*]Your Number []Message Number [_]None
Area Code Phone Number

---

1. a. Where do you live? (Check One.) [x]House [*]Apartment []*Boarding Home [*]Nursing Home []*Shelter [*]Group Home []*Other (What?) _____

b. With whom do you live? (Check One.) [*]Alone [x]With Family []*With Friends [_]Other (Describe Relationship) _____

SECTION B – INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

---

1. How do your illnesses, injuries, or conditions limit your ability to work?

INAbility TO STAND, Walker MOVE REPETITIVEly for ANY EXTENtEd Period. Unable To Firmly grasp with either hand. UNAble to lift heavy objects.

DEA: STCLOS, Case Number: 987654 MSC/205 (06/20) 2 of 9: 4E: Function Report - Adult - 3373 Src: Arthur Miller 12/09/2022

Form SSA-3373 (06-2020) Page 4 of 10

SECTION C – INFORMATION ABOUT DAILY ACTIVITIES

1. Describe what you do from the time you wake up until going to bed. AWAREN, PERSONAL HYGIENE PREPARE CEREAL STRAIGHTEN bed. MENTAL HOUSE CHORES AS NEEDED. Read/WATCH TV. INTERACT ON PHONE,

---

1. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? If "YES," for whom do you care, and what do you do for them?

---

1. Do you take care of pets or other animals? If "YES," what do you do for them?

---

1. Does anyone help you care for other people or animals? If "YES," who helps, and what do they do to help?

---

1. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

---

1. Do the illnesses, injuries, or conditions affect your sleep? If "YES," how? PAIN WAKES ME UP

---

1. PERSONAL CARE (Check here [ ] if No PROBLEM with personal care.) a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress _ *Bathe Care for hair Shave Feed self Use the toilet* _ Other? Unable to STAND for EXTENDED Periods

---

DEA: STOLOS, Case Number: 987654 MSC/205 (06/20)

Back to top Form SSA-3373 (06-2020) b. Do you need any special reminders to take care of personal needs and grooming? If "YES," what type of help or reminders are needed? __

c. Do you need help or reminders taking medicine? If "YES," what kind of help do you need? __

1. MEALS a. Do you prepare your own meals? If "Yes", what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) **Reheated Prepared meals, Soups, ehilly, Single servings** How often do you prepare food or meals? (For example, daily weekly, monthly.) **Reheat daily meals** How long does it take you? **Under 10 MINUTES** Any changes in cooking habits since the illness, injuries, or conditions began? **YES**

   b. If "No," explain why you cannot or do not prepare meals.

   ---

2. HOUSE AND YARD WORK a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing. etc.) **CAN Complete All NECESSARY householo Chores in moderation. And with Time Extended.** b. How much time does it take you, and how often do you do each of these things? **With breaks, 2 or more hours.** c. Do you need help or encouragement doing these things? If "YES", what help is needed? __

   d. If you don't do house or yard work, explain why not.

DEA: ARCTOS, Case Number: 987654 MSC/205 (06/20) 4 of 9: 4E: Function Report - Adult - 3373 Src: Arthur Miller 12/09/2022 Page 6 of 10 Form SSA-3373 (06-2020)

1. GETTING AROUND a. How often do you go outside? FEW DAYS A WEEK If you don't go out at all, explain why not.

b. When going out, how do you travel? (Check all that apply.) [ ] Walk [x] Drive a car [x] Ride in a car [x] Ride a bicycle [ ] Use public transportation [ ] Other (Explain)

c. When going out, can you go out alone? [x] Yes [ ] No If "NO," explain why you can't go out alone.

d. Do you drive? [ ] Yes [x] No If you don't drive, explain why not.

1. SHOPPING a. If you do any shopping, do you shop: (Check all that apply.) [x] In stores [ ] By phone [ ] By mail [ ] By computer b. Describe what you shop for. Personal Needs and groceries.

c. How often do you shop and how long does it take? Depends on Needs and funds. Twice monthly minimum.

1. MONEY a. Are you able to: Pay bills [ ] Yes [x] No Handle a savings account [x] Yes [ ] No Count change [x] Yes [ ] No Use checkbook/money order [x] Yes [ ] No

Explain all "NO" answers. Cost of living exceeds current income.

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? [ ] Yes [x] No If "YES," explain how the ability to handle money has changed.

Form SSA-3373 (06-2020)

1. HOBBIES AND INTERESTS a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

Movies, Watching NATURE, And Sports.

b. How often and how well do you do these things?

Weekly

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

-CANNOT REMAIN Comfortable Through ANY Prolonged ACTIVITY.

2. SOCIAL ACTIVITIES a. How do you spend time with others? (Check all that apply.) - [ ] In person - [x] On the phone - [ ] Email - [x] Texting - [ ] Mail - [ ] Video Chat (for example Skype or Facetime) - [ ] Other (Explain) --- b. Describe the kinds of things you do with others.

CONVERSATION - Exercise

How often do you do these things?

c. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

MOSQUE

Do you need to be reminded to go places? - [ ] Yes - [x] No

How often do you go and how much do you take part?

d. Do you need someone to accompany you? - [ ] Yes - [x] No

If "YES" explain.

e. Do you have any problems getting along with family, friends, neighbors, or others? - [ ] Yes - [x] No

If "YES", explain.

e. Describe any changes in social activities since the illnesses, injuries, or conditions began.

Reduced All ACTIVITIES From discomfort.

ASSESSOR: KESTREL, Case Number: 987654 MSC/205 (06/20) Form SSA-3373 (06-2020) Page 8 of 10 SECTION D - INFORMATION ABOUT ABILITIES

1. a. Check any of the following items your illness, injuries, or conditions affect
   ☒ Lifting ☒ Walking ☒ Stair-Climbing ☐ Understanding ☐ Squatting ☒ Sitting ☐ Seeing ☐ Following Instructions ☒ Bending ☒ Kneeling ☐ Memory ☒ Using Hands ☒ Standing ☒ Talking ☒ Completing Tasks ☒ Getting Along with Others ☐ Reaching ☐ Hearing ☒ Concentration

   Please explain how your Illness, Injuries or conditions affect each
   you can only lift [how many pounds], or you can only walk [how far])
   Discomfort originates from any prolonged activity and inactivity

   _____

b. Are you: ☒ Right Handed? ☐ Left handed?

c. How far can you walk before needing to stop and rest? 1 Block

   _____

   If you have to rest, how long before you can resume walking?
   5 or more minutes

   _____

d. For how long can you pay attention? Depends on interest. ½ hour to 8

   _____

e. Do you finish what you start? (For example: a conversation, chores, watching a movie)

f. How well do you follow written instructions? (For example a recipe)
   Literacy affected by pain.

   _____

g. How well do you follow spoken instructions?
   Word for word.

   _____

h. How well do you get along with authority figures? (For example, poli
   Reasonably as treated.

   _____

i. Have you ever been fired or laid off from a job because of problems along with other people?

If "YES," please explain.

_____

_____

If "YES" please give name of employer. _____

RPU: TEXOMA, Case Number: 987654 MSC/205 (06/20) 7 of 9: 4E: Function Report - Adult - 3373 Src: Arthur Miller 12/09/2022 Form SSA-3373 (06-2020) Page 9 of 10 j. How well do you handle stress?

Minimally

k. How well do you handle changes in routine?

Minimally

l. Have you noticed any unusual behavior or fears? [ ] Yes [x] No If "YES," please explain.

---

1. Do you use of any of the following? (Check all that apply)

   [ ] Crutches [x] Cane [ ] Hearing Aid [ ] Walker [ ] Brace/Splint [x] Glasses/ Contact Lenses [ ] Wheelchair [ ] Artificial Limb [ ] Artificial Voice Box

   [ ] Other (Explain) ___

   Which of these were prescribed by a doctor? None When was it prescribed?

   When do you need to use these aids?

   ## When Reading And Walking.

DEA: ARGUS, Case Number: 987654 MSC/205 (06/20) 8 of 9: 4E: Function Report - Adult - 3373 Src: Arthur Miller 12/09/2022

Form SSA-3373 (06-2020)

1. Do you currently take any medicines for your illnesses, injuries, or conditions? If "YES," do any of your medicines cause side effects?

If "YES," please explain (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE SIDE EFFECTS YOU HAVE

SECTION E - REMARKS Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or If you didn't have anything to add), be sure to complete the fields at the bottom of this page.

Name of person completing this form. (Please print) ARTHUR K. MILLER

Address (Number and Street) 789 Oak Ave

City Chicago

DEA: STOLOS, Case Number: 876543 Page 10 of 10 ☑ Yes ☐ No ☐ Yes ☑ No

Email address (optional)

State IL

MGC/205 (06/20) Date (MM/DD/YYYY) 12-09-2022

ZIP Code 60601

Back to top 9 of 9: 4E: Function Report - Adult - 3373 Src: Arthur Miller 12/09/2022

ROID: L00030987654013
SSN: DOCTYPE:0075 RF:D CS:6f

Claimant: ARTHUR MILLER CASE: 987654 DOB: 05/21/1965

This page must be on top of your Texoma Records Processing Unit questionnaire. PO Box 5001 Slide this page into the return window envelope New Town, KY 40701-0002 with this address showing.

PLEASE NOTE: We have contracted with a specialized vendor to electronically scan all of the correspondence received from you, before it is sent to us. Therefore, your response must be sent to the address as indicated above and in the box to the right.

TO EXPEDITE YOUR RESPONSE FAX RECORDS TO: 1-877-555-4002

The barcode page must be the first page of the returned documents

MSC-112-2

Back to top

1 of 6: 5E: Disability Report - Appeals - 3441 Src: Arthur Miller 05/18/2023 Form Approved OMB No. 0960-0144

DISABILITY REPORT - APPEAL - Form SSA-3441

(3441) Section 1 - Information About the Disabled Person

1.A. Name (First, Middle Initial, Last, Suffix): Arthur Miller 1.B. Social Security Number: 456-12-7890 1.C. Daytime Phone Number, including area code, (include the IDD and country codes if outside the U.S. or Canada): (773) 555-9876 Check this box if you do not have a phone or number where we can leave a message 1.D. Alternate Phone Number - another number where we may reach you, if any: 1.E. Email Address (Optional):

(3441) Section 2 - Contacts

Give the name of someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2.A. Name (First, Middle, Last) Maria Garcia 2.B. Relationship to Disabled Person Friend/Neighbor 2.C. Mailing Address (Street or PO Box) Include apartment number or unit if applicable. 789 Oak Ave City, State/Province, ZIP/Postal Code, Chicago, IL 60601 Country (if not U.S.) 2.D. Daytime Phone Number, including area code (312) 555-0189 (include IDD and country codes if outside the U.S. or Canada)

2.E. Can this person speak and understand English? Yes If no, what language does the contact person prefer?

2.F. Who is completing this form? Someone else (Please complete the information below).

2.G. Name (First, Middle, Last) Eleanor R Walker 2.H. Relationship to Disabled Person Attorney Representative(Attorney/Staff) 2.I. Mailing Address (Street or PO Box) Include apartment number or unit if applicable. 1789 Main Street City, State/Province, ZIP/Postal Code, Suite 201 Country (if not U.S.) Anytown, CA 90210 2.J. Daytime Phone Number, including area code (310) 555-0189 (include IDD and country codes if outside the U.S. or Canada)

Back to top 2 of 6: 5E: Disability Report - Appeals - 3441 Src: Sarah Miller 05/18/2023

(3441) Section 3 - Medical Conditions

Date of Last disability report: 07/22/2022

3.A. Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions? Yes Approximate date change occurred: 1/1/2021 If "Yes", please describe in detail: To the best of our knowledge, since the application was filed the Claimants conditions have continued treatment for the conditions listed on the application, and the Claimants conditions have not improved.

3.B. Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? Yes Approximate date of new conditions: 1/1/2021 If "Yes", please describe in detail: HX of car accident 2012 -chronic hip pain -back injury -herniated discs in back -nerve damage -insomnia - standing difficult -sitting difficult

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 4 - Medical Treatment

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name or nickname. No If "Yes", please list the other names used:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled? Yes

4.C. What type(s) of condition(s) were you treated for, or will you be seen for? Physical and Mental (including emotional or learning problems)

If you answered "Yes" to 4.B., please tell us who may have NEW medical records about any of your physical or mental conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. Complete one page for each provider. If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include: 3 of 6: 5E: Disability Report - Appeals - 3441 Src: Arthur Miller 10/15/2024

doctors' offices hospitals (including emergency room visits) clinics mental health center other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

4.D. Name of Facility or Office	**Sterling Health Clinic**
Name of health care professional who treated you ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.	
Phone Number	(614) 555-0101 - Voice
Mailing Address	456 Oak Avenue Columbus, OH 43215
Patient ID# (if known)	

Dates of Treatment (approximate date, if exact date is unknown)

	Office, Clinic or Outpatient visits	**Emergency Room visits at this facility**	**Overnight hospital stays at this facility**	
First Visit	2020	Date	Date in	Date out
Last Visit	present	Date	Date in	Date out
Next scheduled appointment (if any)		Date	Date in	Date out

What medical conditions were treated or evaluated? multiple medical conditions What treatment did you receive for the above conditions? (Do not list medicines or tests in this box.) regular evaluations and treatment Has this provider

performed or sent you to any tests? Please include tests you are scheduled to have in the future. No

KIND OF TEST	DATES OF TESTS
If you need to list more tests, use SECTION 10 - REMARKS on the last page.	

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

(3441) Section 5 - Other Medical Information

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

This may include:

workers' compensation

Back to top 4 of 6: 5E: Disability Report - Appeals - 3441 Src: Arthur Miller 05/18/2023 vocational rehabilitation services insurance companies who have paid you disability benefits prisons and correctional facilities attorneys social service agencies welfare agencies school/education records No (Go to SECTION 6 - MEDICINES)

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

(3441) Section 6 - Medicines

1. Are you currently taking any medicines (prescription or non-prescription)? No No (Go to SECTION 7 - ACTIVITIES)

(3441) Section 7 - Activities

1. Since you last told us about your activities, has there been any change (for better or worse) in your daily activities due to your physical or mental

conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.) Yes

If yes, please describe in detail: Claimant continues to have difficulty with their activities of daily living due to their current medical conditions.

If you need more space, use SECTION 10- REMARKS on the last page.

(3441) Section 8 - Work and Education

8.A. Since you last told us about your work, have you worked or has your work changed? If yes, you will be asked to provide additional information. No

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school, or college classes? No If yes, what type?

Back to top 5 of 6: 5E: Disability Report - Appeals - 3441 Src: Emily Miller 05/18/2023

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services

1. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in: an individual work plan with an employment network under the Ticket to Work Program? an individualized plan for employment with a vocational rehabilitation agency or any other organization? a Plan to Achieve Self-Support (PASS)? an individualized education program (IEP) through an educational institution (if a student age 18-21)? any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

No (Go to SECTION 10 - REMARKS)

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 10 - Remarks

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.). Please contact our office regarding any additional information needed to properly process this claim. Please forward a barcode for this Claimant so we may submit medical updates.

Back to top 6 of 6: 5E: Disability Report - Appeals - 3441 Src: Maria Rodriguez 05/18/2023

I 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 UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	**Date (Month, day, year)**
Address (Number and street, city, state and ZIP code) 789 Oak Ave Chicago, IL 60601	e-mail Address (optional)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	**2. Signature of Witness**
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form NBA-3441 EDCS Thursday, May 18, 2023 08:01:26

Back to top

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

(3367) ID/Prior Filings

Identifying Information

1. Name of person(s) on whose Social Security record(s) this claim is being filed: Arthur Miller His or Her Social Security Number(s): 456-12-7890 Name of Claimant (if different from above): SSN (if different from above): Gender: Male Date of Birth: 05/21/1965
2. Claimant's Alleged Onset Date: 07/01/2022
3. Potential Onset Date:
4. Reason for Potential Onset Date:
5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

1. Protective Filing Date: Non-Blind Date Last Insured (DIB/Freeze case): Blind Date Last Insured (DIB/Freeze case): Closed Period Case:

Prior Filing Information

1. Prior Filing(s): If "Yes" and you are not sending the prior folder, enter the following:

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no initial level SSI claim on this case.

(3367) Observations

1. Observations/Perceptions:

   How was the Interview Conducted? No contact with claimant (Select all that apply)

Back to top 2 of 2: 6E: Disability Report - Field Office - 5588 Src: CO 06/15/2024 Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

(5588) Development

---

1. Development Initiated by CO: A. Medical: B. Other: C. Forms to be completed by applicant and sent to the DDS: SSA-3371: SSA-3369: Other:
2. Was medical evidence brought in to the CO by the claimant? No
3. Is DDS capability development needed? No Remarks:

Name of Interviewer: J. Miller Phone Number: 888-999-1234 Name of Person Completing Form: J. Miller Date: 06/15/2024

Form SSA-5588 EDCS Friday, June 15, 2024 08:01:27

1 of 8: 7E: Function Report - Adult - NBA-5000 Src: Arthur Miller 01/15/2024 Form NBA-5000 (01-2024) Page 3 of 10 Discontinue Prior Editions OMB No. 1234-5678 National Benefits Agency 987654321098765

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For NBA Use Only Do not write in this box.

[BARCODE IMAGE REPRESENTATION] RQID:ABC123456789 SITE:X99 DR:Z SSN: DOCTYPE:9999 RF:A CS:1234

Anyone who makes or causes to be made a false statement or representation of material fact for use in determining a payment under the National Benefits Act, or knowingly conceals or fails to disclose an event with an intent to affect an initial or continued right to payment, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

SECTION A - GENERAL INFORMATION

1. NAME OF DISABLED PERSON (First, Middle Initial, Last) 2. SOCIAL SECURITY NUMBER Arthur Miller 456-12-7890

2. YOUR DAYTIME TELEPHONE NUMBER (If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)

773 555-9876 [x]Your Number [ ]Message Number [ ]None Area Code Phone Number

1. a. Where do you live? (Check one.)

[x]House [ ]Apartment [ ]Boarding House [ ]Nursing Home [ ]Shelter [ ]Group Home [ ]Other (What?)

b. With whom do you live? (Check one.)

[ ]Alone [x]With Family [ ]With Friends [ ]Other (Describe relationship.)

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

1. How do your illnesses, injuries, or conditions limit your ability to work?

INAbility TO STAND for Prolonged Periods. Unable to lift objects overhead. CANNOT WALK for diSTANCES THAT ARE lengthy.

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

1. Describe what you do from the time you wake up until going to bed. Arise From bed, Personal Hygiene Attention. Prepare And Eat breakfast, Minor home Maintenance. Review Latest local News Information. Stream Entertainment. Eat Dinner. Return to Bed for Evening

1. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? If "YES," for whom do you care, and what do you do for them? ☐ Yes ☒ No

2. Do you take care of pets or other animals? If "YES," what do you do for them? ☐ Yes ☒ No

3. Does anyone help you care for other people or animals? If "YES," who helps, and what do they do to help? ☐ Yes ☒ No

4. What were you able to do before your illnesses, injuries, or conditions that you can't do now? Sandblasting, Landscaping, Furniture Moving, Exercise.

5. Do the illnesses, injuries, or conditions affect your sleep? If "YES," how? ☒ Yes ☐ No

6. PERSONAL CARE (Check here ☐ if NO PROBLEM with personal care.) a. Explain how your illnesses, injuries, or conditions affect your ability to:

   Dress Takes longer to dress due to Inability to lift overhead.

   Bathe Mobility Affected by slippery Surfaces

   Care for hair Occasionally barber visits when Affordable.

   Shave OK

Feed self OK

Use the toilet OK

Other

 b. Do you need any special reminders to take care of personal needs and grooming? If "YES," what type of help or reminders are needed?

☐ Yes ☑ No

c. Do you need help or reminders taking medicine? If "YES," what kind of help you need?

☐ Yes ☑ No

1. MEALS a. Do you prepare your own meals? If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) ☑ Yes ☐ No Sandwiches. Reheated microwave meals. How often do you prepare food or meals? (For example, daily, weekly, monthly.) Daily Breakfast, Lunch and Dinner. How long does it take you? 30 minutes Any changes in cooking habits since the illness, injuries, or conditions began?

   ## No

b. If "No," explain why you cannot or do not prepare meals.

Takes time due to discomfort From prolonged Standing.

1. HOUSE AND YARD WORK a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) Laundry, Dusting, Dishwashing, Vacuuming. b. How much time does it take you, and how often do you do each of these things? 2 to 3 hours. 3-5 times weekly c. Do you need help or encouragement doing these things? If "YES," what help is needed? ☑ Yes ☐ No Assistance with Tools, operations, And finishing chores. d. If you don't do house or yard

work, explain why not. Pain From Mobility concerns limit Variation and Range. 1008800933 8022678 4 of 8: 7E: Function Report - Adult - 3373 Src: Arthur Miller 07/26/2023 Form SSA-3373 (10-2020)

15. GETTING AROUND

a. How often do you go outside? _ Daily If you don't go out at all, explain why not.

b. When going out, how do you travel? (Check all that apply.)

- [x] Walk [x] Drive a car [x] Ride in a car [ ] Ride a bicycle
- [ ] Use public transportation [ ] Other (Explain) _

c. When going out, can you go out alone? [x] Yes [ ] No If "NO," explain why you can't go out alone.

d. Do you drive? [ ] Yes [x] No

If you don't drive, explain why not.

16. SHOPPING

a. If you do any shopping, do you shop: (Check all that apply.)

- [x] In stores [ ] By phone [ ] By mail [ ] By computer

b. Describe what you shop for. __ SUSTENANCE, Clothing.

c. How often do you shop and how long does it take?

__ Weekly as Needed. 3 to 6 hours

17. MONEY

a. Are you able to:

- Pay bills [x] Yes [ ] No Handle a savings account [x] Yes [ ] No
- Count change [x] Yes [ ] No Use a checkbook/money orders [x] Yes [ ] No Explain all "NO" answers.

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? [ ] Yes [x] No If "YES," explain how the ability to handle money has changed.

–

9876543

5 of 8: 7E: Function Report - Adult - 3373 Src: Arthur Miller 07/26/2023

Form SSA-3373 (10-2020) Page 7 of 10

1. HOBBIES AND INTERESTS 122307260001779

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

WATching TELEVISION, Listεύως το music. Video gaming. Solving Puzzles, Chess,

b. How often and how well do you do these things?

Daily. Learning to get better AT All Activities

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

Delays. IN.Timely Completion.

1. SOCIAL ACTIVITIES

a. Do you spend time with others? (Check all that apply.) [x] In person [x] On the phone [ ] Email [x] Texting [x] Mail

[ ] Video Chat (for example Skype or Facetime) [ ] Other (Explain)

b. Describe the kinds of things you do with others.

CONVERSATIONS, CHESS, Cooking/grillrang

How often do you do these things?

Weekly

c. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

Religious ObserVANCES. COMMUNITY EVEιστς.

Do you need to be reminded to go places? [ ] Yes [x] No How often do you go and how much do you take part?

As occurrences happen. Daily, Weekly And Monthly.

Do you need someone to accompany you? [ ] Yes [x] No

If "YES", explain.

d. Do you have any problems getting along with family, friends, neighbors, or others? If "YES," explain. [x] Yes [ ] No

OCCASSIONAT Family TENSIONS Arise Over MONEY, bills ETC

e. Describe any changes in social activities since the illnesses, injuries, or conditions began.

9876543210 1234567 Back to top 6 of 8: 7E: Function Report - Adult - 3373 Src: Arthur Miller XX/XX/XXXX

1. a. Check any of the following items that your illnesses, injuries, or conditions affect: [x] Lifting [x] Walking [x] Stair Climbing [x] Understanding [x] Squatting [x] Sitting [x] Seeing [x] Following Instructions [x] Bending [x] Kneeling [x] Memory [x] Using Hands [x] Standing [ ] Talking [x] Completing Tasks [x] Getting Along With Others [x] Reaching [ ] Hearing [x] Concentration

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far].) No heavy lifting. SQUATTING INSTAbility And dizzyNESS WHEN RETURNED TO STRiding SAME bending. UNAble to STAND steady for long. CAN'T REACH overhead. Walking with CONSTANT limp. Legs fall "Sleep" WHEN SISTING. KNEEling PAINFUL WHENPraying STAITS ARE Tiring More THAN ONE Flight. Need Reading glASSES, CONCENTRATION, Memory ETS PAIN EAREDE

b. Are you: [x] Right Handed? [ ] Left Handed? c. How far can you walk before needing to stop and rest?

- 100 FT If you have to rest, how long before you can resume walking? 10+ mwUTES

d. For how long can you pay attention? Short Term

e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie.) [ ] Yes [x] No

f. How well do you follow written instructions? (For example, a recipe.) LOSES CONCENTRATION with lengththly REQUIREMENTS

g. How well do you follow spoken instructions? VISUAL LEARNEç.

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.) (σερεΓAative with Authority.

i. Have you ever been fired or laid off from a job because of problems getting along with other people? [ ] Yes [x] No If "YES," please explain. N/A If "YES," please give name of employer. N/A

j. How well do you handle stress? 987654321098765 Minimally k. How well do you handle changes in routine? MINIMAlly l. Have you noticed any unusual behavior or fears? [ ] Yes [x] No If "YES," please explain. N/A

1. Do you use any of the following? (Check all that apply.) [ ] Crutches [x] Cane [ ] Hearing Aid [ ] Walker [ ] Brace/Splint [x] Glasses/Contact Lenses [ ] Wheelchair [ ] Artificial Limb [ ] Artificial Voice Box [ ] Other (Explain)

Which of these were prescribed by a doctor? NONE

When was it prescribed? N/A

When do you need to use these aids? After prolonged Periods of Activity.

9876543210 9876543

8 of 8: 7E: Function Report - Adult - 3373 Src: Arthur Miller 07/26/2023 Page 10 of 10

Form SSA-3373 (10-2020)

1. Do you currently take any medicines for your illnesses, injuries, or conditions? [ ] Yes [x] No If "YES," do any of your medicines cause side effects? [ ] Yes [x] No If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE
N/A	N/A

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

UNABLE TO MAINTAIN EMPLOYMENT DUE TO INABILITY TO CONSISTENTLY PERFORM REQUIRED TASKS. ATTEMPTS TO MEET NECESSARY PERSONAL TASKS ARE ALSO hampered by mobility CONCERNS.

Name of person completing this form (Please print) Date (MM/DD/YYYY) Arthur Miller 05/21/1965

Address (Number and Street) Email address (optional). 789 Oak Ave arthur.miller.claim@fakemail.net

City State ZIP Code Chicago IL 60601

9876543.

Form Approved OMB No. 0960-0144

DISABILITY REPORT - APPEAL - Form SSA-3441

(3441) Section 1 - Information About the Disabled Person

1.A. Name (First, Middle Initial, Last, Suffix): Arthur Miller 1.B. Social Security Number: 456-12-7890 1.C. Daytime Phone Number, including area code, (include the IDD and country codes if outside the U.S. or Canada): (773) 555-9876

Check this box if you do not have a phone or number where we can leave a message 1.D. Alternate Phone Number - another number where we may reach you, if any: 1.E. Email Address (Optional):

(3441) Section 2 - Contacts

Give the name of someone (other than your doctors) we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2.A. Name (First, Middle, Last) Sophia Garcia 2.B. Relationship to Disabled Person Friend/Neighbor 2.C. Mailing Address (Street or PO Box) 789 Oak Ave Include apartment number or unit if applicable. City, State/Province, ZIP/Postal Code, Chicago, IL 60601 Country (if not U.S.) 2.D. Daytime Phone Number, including area code (312) 555-0180 (include IDD and country codes if outside the U.S. or Canada) 2.E. Can this person speak and understand English? Yes If no, what language does the contact person prefer? 2.F. Who is completing this form? Someone else (Please complete the information below). 2.G. Name (First, Middle, Last) Eleanor Walker 2.H. Relationship to Disabled Person Appointed Representative(Attorney/Staff) 2.I. Mailing Address (Street or PO Box) 1789 Main Street Include apartment number or unit if applicable. Suite 201 City, State/Province, ZIP/Postal Code, Anytown, CA 90210 Country (if not U.S.) 2.J. Daytime

Phone Number, including area code (310) 555-0189 (include IDD and country codes if outside the U.S. or Canada)

Back to top 2 of 6: 8E: Disability Report - Appeals - 3441 Src: Arthur Miller 09/21/2023

(3441) Section 3 - Medical Conditions

Date of Last disability report: 05/18/2023

3.A. Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions? No Approximate date change occurred:

If "Yes", please describe in detail:

3.B. Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? No Approximate date of new conditions:

If "Yes", please describe in detail:

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 4 - Medical Treatment

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name or nickname. No If "Yes", please list the other names used:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or do you have a future appointment scheduled? No

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

If you answered "Yes" to 4.B., please tell us who may have NEW medical records about any of your physical or mental conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. Complete one page for each provider. If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include: doctors' offices hospitals (including emergency room visits)

Back to top 3 of 6: 8E: Disability Report - Appeals - 3441 Src: Arthur Miller 09/21/2023

clinics mental health center other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

(3441) Section 5 - Other Medical Information

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

This may include: workers' compensation vocational rehabilitation services insurance companies who have paid you disability benefits prisons and correctional facilities attorneys social service agencies welfare agencies school/ education records

No (Go to SECTION 6 - MEDICINES)

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

(3441) Section 6 - Medicines

1. Are you currently taking any medicines (prescription or non-prescription)?

No (Go to SECTION 7 - ACTIVITIES)

(3441) Section 7 - Activities

1. Since you last told us about your activities, has there been any change (for better or worse) in your daily activities due to your physical or mental conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

No

Back to top 4 of 6: 8E: Disability Report - Appeals - 3441 Src: Arthur Miller 09/21/2023

If yes, please describe in detail:

If you need more space, use SECTION 10- REMARKS on the last page.

(3441) Section 8 - Work and Education

8.A. Since you last told us about your work, have you worked or has your work changed? If yes, you will be asked to provide additional information. No

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of GED classes, specialized job training, trade school, vocational school, or college classes? No If yes, what type?

Date(s) attended:

Degree(s) attained, if any:

Date of attainment (MM/YYYY):

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services

1. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?

- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work? No (Go to SECTION 10 - REMARKS)

If you need more space, use SECTION 10 - REMARKS on the last page.

Back to top 5 of 6: 8E: Benefit Application - Review - 9876 Src: Sarah Thompson 10/15/2024

(9876) Section 8 - Notes

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

Please let this letter serve as an objection to the video teleconferenced (VTC) hearing format. We hereby request a telephone or in-person hearing. Please forward a barcode for this Claimant so we may submit medical updates.

Back to top 6 of 6: 8E: Disability Report - Appeals - 3441 Src: Arthur Miller 10/15/2024

I 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 UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

Signature of claimant or person filing on claimant's behalf (parent, guardian)	**Date (Month, day, year)**
Address (Number and street, city, state and ZIP code)	**e-mail Address (optional)**
789 Oak Ave CHICAGO, IL 60601-1001	

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	**2. Signature of Witness**
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form NBA-5678 DCMIS Monday, October 15, 2024 11:45:30

Back to top

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367

(3367) ID/Prior Filings

Identifying Information

1. Name of person(s) on whose Social Security record(s) this claim is being filed: Arthur Miller His or Her Social Security Number(s): 456-12-7890 Name of Claimant (if different from above): SSN (if different from above): Gender: Male Date of Birth: 05/21/1965
2. Claimant's Alleged Onset Date: 07/01/2022
3. Potential Onset Date:
4. Reason for Potential Onset Date:
5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

1. Protective Filing Date: Non-Blind Date Last Insured (DIB/Freeze case): Blind Date Last Insured (DIB/Freeze case): Closed Period Case:

Prior Filing Information

1. Prior Filing(s): If "Yes" and you are not sending the prior folder, enter the following:

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no initial level SSI claim on this case.

(3367) Observations

1. Observations/Perceptions:

Back to top 2 of 2: 9E: Disability Report - Field Office - 3367 Src: FO 09/21/2023

(3367) Development

1. Development Initiated by FO: A. Medical: B. Other: C. Forms to be completed by applicant and sent to the DDS: SSA-3371: SSA-3369: Other:
2. Was medical evidence brought in to the FO by the claimant? No
3. Is DDS capability development needed? No Remarks:

Name of Interviewer: Arthur Pendragon Phone Number: 888-999-1234 Name of Person Completing Form: Date:

Form SSA-3367 EDCS Thursday, September 21, 2023 09:10:25

1 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

NATIONAL BENEFITS AGENCY

BNC#: 24GO129J91327

Refer To: Arthur Miller

Eleanor R Walker WALKER ASSOCIATES PC 1789 Main Street, Suite 201, Anytown, CA 90210 Appeals Division NBA APPEALS OFC Unit B, 777 Suburban Way, Cityville, MI 48009 Tel: (877) 888-7000 / Fax: (833) 555-4000

February 29, 2024

Dear Eleanor R Walker:

The above named claimant has filed a request for a National Benefits Agency hearing, and the record shows that you are representing this person.

Proposed exhibits in the above referenced file are now ready for your review. Please log into www.nationalbenefitsagency.gov/appeals/ to view the proposed exhibits which are shown in the exhibit list tab. Further processing of this case requires the following actions on your part:

1. It is the claimant's responsibility to provide medical evidence showing that he/she has an impairment(s) and how severe it is during the time he or she alleges disability. In order to expedite processing of this claim, you should submit the following information: a. All medical records (not duplicates) from one year prior to the alleged onset date to the present and any other relevant medical, school or other records not already in file. Please refer to your client's electronic folder to avoid submitting duplicate records. b. Completed enclosed questionnaire(s), and signed Authorization to Disclose Information (enclosed).

2. Advise us when all relevant evidence is up-to-date and the case is ready to be scheduled.

Form HA-L56 (05-2011)
Claimant

Back to top See Next Page 2 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Please submit all evidence using one of the three electronic methods:

1. Fax using the enclosed barcode to the FECS server number (877) 555-4001,
2. ARS (Appointed Representative Services) website or
3. Contract Scanner (Note: Please do not send original documents directly to the contract scanner as they will not be returned.)

Cityville Appeals Office P.O. Box 5000 New Town, KY 40701-0001

As soon as you submit the foregoing, we will review your case to determine if we can make a fully favorable decision without holding a hearing. If we cannot make a decision on the record, we will schedule your case for hearing. Therefore, it is to your advantage to submit your evidence as soon as possible.

If you have any questions, please contact the number listed above.

Sincerely,

Sir Reginald Appeals Office Director

Enclosures: HA-4631 (Claimant's Recent Medical Treatment) HA-4632 (Claimant's Medications) HA-4633 (Claimant's Work Background) SSA-827 (Authorization to Disclose Information to the Social Security Administration (SSA))

cc: Arthur Miller 789 Oak Ave Chicago, IL 60601-1001

Form HA-L56 (05-2011) Claimant 3 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

National Benefits Agency Form Approved

OMB No.0960-0292

CLAIMANT'S RECENT MEDICAL TREATMENT

A. To be completed by appeals office

(Claimant and National Benefits Number)	**(Wage Earner and National Benefits Number)**	**The last time we brought your**
Arthur Miller	(Leave blank if same as claimant)	case up-to-date was: August 30, 2023

B. To be completed by claimant

PLEASE PRINT

Please Answer the Following Questions:

(1) Have you been treated or examined by a doctor (other than a doctor at a hospital) since the above date? [ ] Yes [ ] No

(If yes, please list the name, addresses and telephone numbers of doctors who have treated or examined you since the above date. Also list dates of treatment or examination. If possible, send updated reports from these doctors to the Administrative Appeals Judge prior to the date of your hearing.)

DOCTORS' NAME(S) ADDRESS(ES) & TELEPHONE NO.(S) DATE(S)

(2) What have these doctors told you about your condition?

(3) Have you been hospitalized since the above date? [ ] Yes [ ] No

(If yes, please list the name and address of the hospital. Also explain why you were hospitalized and what treatment you received.)

Name of Hospital | Address of Hospital (Include ZIP Code)
----------|_ |_

Reason for hospitalization:

Treatment received:

Form HA-4631 (8-1996) ef (9-2012) [Barcode Image Placeholder] Issue Old Stock use additional sheets.

[Placeholder for system trac

4 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (C) of the National Benefits Agency Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed or could result in denial of the claim.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his or her affairs or his or her eligibility for or entitlement to benefits under the National Benefits Agency program when the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns his or her eligibility for benefits under the National Benefits Agency program; and

2. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the National Benefits Agency Act.

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 (SORN) 80-0001, entitled Benefits Case System, and 80-0002, entitled Digital Claims File. Additional information and a full listing of all our SORNs are available on our website at www.nationalbenefitsagency.gov/records/sorn.html.

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. You may send comments on our time estimate above to: NBA, PO Box 5002, New Town, KY 40701-0003. Send only comments relating to our time estimate to this address, not the completed form.

Form NB-1001 (Rev. 2020) ef (Rev. 2023)

Back to top 5 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville AO 02/29/2024

NATIONAL BENEFITS AGENCY (NBA) Form Approved OMB No.0960-0289

CLAIMANT'S MEDICATIONS

A. To be completed by Hearing Office	**(Wage Earner and Social Security Number)**	**The last time we brought your case up-to-date was:**
(Claimant and Social Security Number) Arthur Miller	(Leave blank if same as claimant)	August 30, 2023

B. To be completed by the claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	**DATE FIRST PRESCRIBED**	**DAILY AMOUNT TAKEN**	**REASONS FOR MEDICATION**	**NAME OF PHYSICIAN**

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

Form HA-4632 (2-1994) ef (10-2012) Use Until Stock Is Exhausted RQID:FAKEID12345 SITE:Y78 DR:T SSN:\\\\\ DOCTYPE:3045 RF:D CS:2f3c If more space is needed, use additional sheets. 6 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Privacy Act Statement
Collection and Use of Personal Information

Sections 205, 223, 702, 1614, 1631, and 1869 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 re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To representative payees, when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting the National Benefits Agency in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and

2. To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the

extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting NBA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

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 (SORN) 60-0089, entitled Claims Folders System 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.nationalbenefitsagency.gov/privacy.

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 15 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form HA-4632 (2-1994) ef (10-2012)

Back to top 7 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Form HA-4633 (09-2023) UF Discontinue Prior Editions National Benefits Agency Page 1 of 2 OMB No. 0960-0300

CLAIMANT'S WORK BACKGROUND

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number)	The last time we brought your case up-to-date was:
Arthur Miller	(Leave blank if same as claimant)	August 30, 2023

B. To be completed by the claimant

PLEASE PRINT

Start with your most recent job, and list that and any work performed within the past 15 years.

DATE OF EMPLOYMENT (APPROXIMATELY)	NAME OF EMPLOYER AND LOCATION OF EMPLOYMENT	DUTIES PERFORMED
FROM TO		
FROM TO		
FROM TO		
FROM TO		

RQID:NBAS05212410301519007890 SITE:Y78 DR:T SSN: DOCTYPE:3050 RF:D CS:a4b0

Back to top 8 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 702, 1631(e)(1) and 1869(b)(1)(C) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is

voluntary. However, failure to provide all or part of the information may prevent us from making an accurate and timely decision on any claim filed.

We will use this information you provide to determine benefits eligibility. We may also share your information for the following purposes, called routine uses:

To contractors and other Federal agencies, as necessary, for the purpose of assisting NBA in the efficient administration of our programs; and To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Social Security Act. 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 (SORN) 60-0089, entitled Claims Folders System as published in the Federal Register (FR) on October 31, 2019, at 84 FR 58422, and 60-0320, Electronic Disability Claim File, as published in the FR on June 4, 2020, at 85 FR 34477. Additional information, and a full listing of all our SORNs, is available on our website at www.nationalbenefitsagency.gov.

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 30 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form. 9 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Whose Records to be Disclosed

NAME (First, Middle, Last, Suffix)

Arthur Miller

SSN	Birthday (MM/DD/YYYY)
456-12-7890	05/21/1965

AUTHORIZATION TO DISCLOSE INFORMATION TO

THE NATIONAL BENEFITS AGENCY (NBA)

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 50 CFR 201.501) 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	**THIS BOX TO BE COMPLETED BY NBA/BPS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:**
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 NBA Employers, insurance companies, workers' compensation programs Others who may know about my condition (family, neighbors, friends, public officials)	
TO WHOM	The National Benefits Agency and to the State agency authorized to process my case (usually called "benefits processing services"), including contract document services, and doctors or other professionals consulted during the process. [Also, for international applications, to the U.S. Department of State Overseas Service Post.]

FROM WHOM	**THIS BOX TO BE COMPLETED BY NBA/BPS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:**
PURPOSE	Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet NBA'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 NBA and my sources to revoke this authorization at any time (see page 2 for details). NBA 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.	
---	---

FROM WHOM	**THIS BOX TO BE COMPLETED BY NBA/BPS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the 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	IF not signed by subject of disclosure, specify basis for authority to sign		
INDIVIDUAL authorizing disclosure Signature	[ ] Parent of minor [ ] Guardian [ ] Other personal representative (explain)		
	(Parent/guardian/personal representative sign here if two signatures required by Jurisdiction law)		
Date Signed	Street Address		
	789 OAK AVE		
Phone Number (with area code)	City	State	ZIP
(773) 555-9876	Chicago	IL	60601
---	---		
WITNESS I know the person signing this form or am satisfied of this person's identity:	IF needed, second witness sign here (e.g., if signed with "X" above)		
Signature			
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. 111-222 ("HEALTH INFO ACT"); 50 CFR parts 200 and 201; 48 U.S. Code section 333ee-3; 48 CFR part 3; 40 U.S. Code section 8888; 40 CFR 2.900; 22 U.S. Code section 5678a ("EDUCATION PRIVACY ACT"); 36 CFR parts 101 and 404; and Jurisdiction law. 10 of 21: 10E: Exhibit List to Rep PH2E -

Explanation of Form NBA-827,

"Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 NBA-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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA makes every reasonable effort to ensure that the information in the NBA-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 contracts where necessary to establish or verify information provided by representative payees or payee 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) NBA Claims Records, NBA Master Client File, NBA Electronic Case File, and NBA Supplemental Assistance Records. Additional information and a full listing of all our SORNs are available on our website at www.nationalbenefitsagency.gov/transparency/publicrecords.

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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top

11 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

NATIONAL BENEFITS AGENCY Office of Appeals Division BNC#: AD12WE45G67890J NBA APPEALS OFFICE UNIT B 777 SUBURBAN WAY CITYVILLE, MI 48009 Refer To: Tel: (877) 888-7000 / Fax: (833) 555-4000 Arthur Miller February 29, 2024

Eleanor Rose Walker WALKER ASSOCIATES PC 1789 MAIN STREET SUITE 201 ANYTOWN, CA 90210

Dear Eleanor Rose Walker:

The above named claimant has filed a request for a National Benefits hearing, and the record shows that you are representing this person.

Proposed exhibits in the above referenced file are now ready for your review. Please log into www.nationalbenefitsagency.gov/repaccess/ to view the proposed exhibits which are shown in the exhibit list tab. Further processing of this case requires the following actions on your part:

1. It is the claimant's responsibility to provide medical evidence showing that he/she has an impairment(s) and how severe it is during the time he or she alleges disability. In order to expedite processing of this claim, you should submit the following information:

a. All medical records (not duplicates) from one year prior to the alleged onset date to the present and any other relevant medical, school or other records not

already in file. Please refer to your client's electronic folder to avoid submitting duplicate records.

b. Completed enclosed questionnaire(s), and signed Authorization to Disclose Information (enclosed).

1. Advise us when all relevant evidence is up-to-date and the case is ready to be scheduled.

Form HA-L56 (05-2011) Representative

See Next Page

Arthur Miller BNC#: AD12WE45G67890J Please submit all evidence using one of the three electronic methods:

1. Fax using the enclosed barcode to the Electronic Records server number (877) 555-4001,
2. Representative Electronic Submission System (RESS) or
3. Contract Scanner (Note: Please do not send original documents directly to the contract scanner as they will not be returned.)

CITYVILLE APPEALS OFFICE P.O. Box 5000 New Town, KY 40701-0001

As soon as you submit the foregoing, we will review your case to determine if we can make a fully favorable decision without holding a hearing. If we cannot make a decision on the record, we will schedule your case for hearing. Therefore, it is to your advantage to submit your evidence as soon as possible.

If you have any questions, please contact the number listed above.

Sincerely,

Director of Appeals

Enclosures: NBA-4631 (Claimant's Recent Medical History) NBA-4632 (Claimant's Current Medications) NBA-4633 (Claimant's Employment History) NBA-827 (Authorization to Disclose Information to the National Benefits Agency (NBA))

cc: Arthur Miller 789 Oak Ave Chicago, IL 60601-1001

Form NBA-L56 (05-2011) Representative 13 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 03/15/2025

National Benefits Agency (NBA) Form Approved OMB No.0960-0292

CLAIMANT'S RECENT MEDICAL TREATMENT

A. To be completed by hearing office

(Claimant and Social Security Number)	**(Wage Earner and Social Security Number)**	**The last time we brought your**
Arthur Miller	(Leave blank if same as claimant)	case up-to-date was: September 10, 2024

B. To be completed by claimant

PLEASE PRINT

Please Answer the Following Questions:

(1) Have you been treated or examined by a doctor (other than a doctor at a hospital) since the above date? [] Yes [] No

(If yes, please list the name, addresses and telephone numbers of doctors who have treated or examined you since the above date. Also list dates of treatment or examination. If possible, send updated reports from these doctors to the Administrative Law Judge prior to the date of your hearing.)

DOCTORS' NAME(S) ADDRESS(ES) & TELEPHONE NO.(S) DATE(S)

(2) What have these doctors told you about your condition?

---

(3) Have you been hospitalized since the above date? [] Yes [] No (If yes, please list the name and address of the hospital. Also explain why you were hospitalized and what treatment you received.)

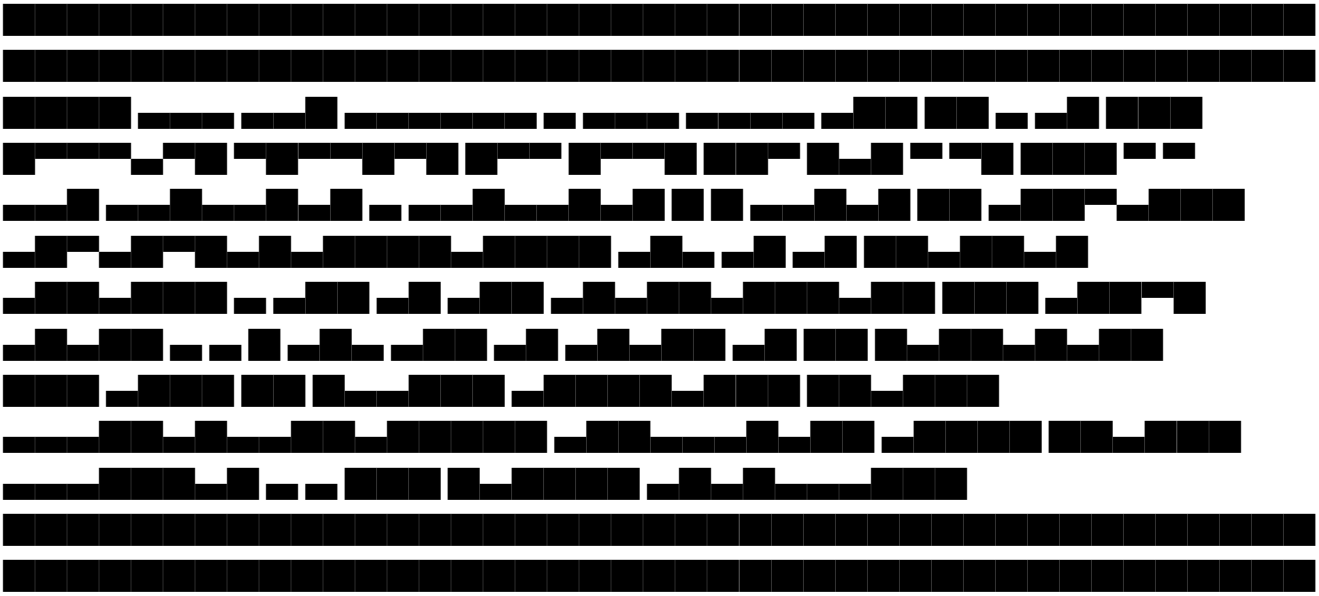
Name of Hospital Address of Hospital (Include ZIP Code)

– —

Reason for hospitalization:

Treatment received:

Form HA-4631 (8-1996) ef (9-2012) Issue Old Stock



RQID:NBASØ31525012034560078 90 SITE:Y12 DR:A SSN: DOCTYPE:4050 RF:E CS:gh20 If more space is needed, use additional sheets.

Back to top 14 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (C) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed or could result in denial of the claim.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his or her affairs or his or her eligibility for or entitlement to benefits under the Social Security program when the data are needed to establish the validity of evidence or to verify the accuracy of information

presented by the individual, and it concerns his or her eligibility for benefits under the Social Security program; and
2. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act.

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 (SORN) 60-0089, entitled Claims Folders System, and 60-0320, entitled Electronic Disability (eDIB) Claim File. Additional information and a full listing of all our SORNs are available on our website at www.nationalbenefitsagency.gov/privacy/sorn.html.

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. You may send comments on our time estimate above to: NBA, 789 Administrative Drive, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form HA-4631 (8-1996) ef (9-2012)

Back to top 15 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

NATIONAL BENEFITS AGENCY

Form Approved

OMB No.0960-0289

CLAIMANT'S MEDICATIONS

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number)	The last time we brought your case
Arthur Miller	(Leave blank if same as claimant)	up-to-date was: August 30, 2023

B. To be completed by the claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASONS FOR MEDICATION	NAME OF PHYSICIAN

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

If more space is needed, use additional sheets.

[BARCODE IMAGE REPRESENTATION]

RQID:FAKE12345678901234567890 SITE:Y99 DR:T

SSN:456127890 DOCTYPE:9876 RF:E CS:8a9b

16 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

Privacy Act Statement Collection and Use of Personal Information

Sections 205, 223, 702, 1614, 1631, and 1869 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 re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To representative payees, when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting the National Benefits Agency in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and
2. To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting NBA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

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 (SORN) 60-0089, entitled Claims Folders System 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.nationalbenefitsagency.gov/privacy.

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 15 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form HA-4632 (2-1994) ef (10-2012)

Back to top Form HA-4633 (09-2023) UF Page 1 of 2 Discontinue Prior Editions OMB No. 0960-0300 National Benefits Agency (NBA)

CLAIMANT'S WORK BACKGROUND

A. To be completed by Appeals Division

(Claimant and National Benefits Number)	**(Wage Earner and National Benefits Number)**	**The last time we brought your case up-to-date was:**
Arthur Miller	(Leave blank if same as claimant)	August 30, 2023

B. To be completed by the claimant

PLEASE PRINT

Start with your most recent job, and list that and any work performed within the past 15 years.

DATE OF EMPLOYMENT (APPROXIMATELY)	NAME OF EMPLOYER AND LOCATION OF EMPLOYMENT	DUTIES PERFORMED
FROM TO		
FROM TO		
FROM TO		
FROM TO		

RQID:FAKE01012510000000000000 SITE:X99 DR:Z
NBN:-- DOCTYPE:3050 RF:D CS:f435 Form HA-4633 (09-2023) UF

Personal Information

Name: Arthur Miller Date of Birth: 05/21/1965 Address: 789 Oak Ave, Chicago, IL 60601-1001 Phone Number: (773) 555-9876 Email: arthur.miller.claim@fakemail.net Social Security Number: 456-12-7890 Gender: Male Place of Birth: Chicago, Illinois U.S. Citizen: Yes Currently married: Yes Prior marriages: Yes (1) Have any children: Yes Child's Name: Emily Miller Claim Number: 456-12-7890 Case Number: 987654 BNC#: AD12WE45G67890J Other Identifier: C-987654321

Member ID: 0123456789-9876543210

Service Provider Information

Name: Legal Advocates for the Disabled / Walker & Associates PC (Eleanor R. Walker) Name Variations: Legal Advocates for the Disabled, Walker, Thompson & Peterson, P.C., WALKER ASSOCIATES PC, LAW OFFICES LEGAL ADVOCATES FOR THE DISABLED WALKER, THOMPSON & PETERSON, P.C. Associated Person: Eleanor R Walker / Eleanor Rose Walker / Eleanor Walker / Attorney Eleanor R. Walker Address: 1789 Main Street, Suite 201, Anytown, CA 90210 Phone Number: (310) 555-0189 (Also listed: 310-555-0234) Fax Number: (310) 555-0190 EIN: 88-7776655 Rep ID: ZQA9W8ERTG

Relationship to Person Applying: Attorney Representative / Appointed Representative

Name: National Benefits Agency (NBA) / Appeals Division Address (Main): 1 Central Square, Capital City, DC 20001 Address (Metropolis Field Office): Suite 100, 450 Riverfront Ave, Metropolis, MI 48201 Address (Cityville Appeals Office): Unit B, 777 Suburban Way, Cityville, MI 48009 Address (Appeals Mailing): P.O. Box 5000, New Town, KY 40701-0001 Address (Texoma Records Processing Unit): Floor 3, 99 Downtown Blvd, Texoma, TX 75001-1234 / PO Box 5001, New Town, KY 40701-0002 Address (General Mail): PO Box 5002, New Town, KY 40701-0003 Phone Number (General): 1-800-555-0100 Phone Number (TTY): 1-800-555-0101 Phone Number (Metropolis Field Office): (888) 999-1234 / 888-999-1235 Phone Number (Cityville Appeals Office): (877) 888-7000 Phone Number (Texoma RPU HelpDesk): 877-555-2000 Phone Number (Fraud Hotline): (800) 999-3000 / 1-800-999-3000 (TTY 1-866-999-3001) Fax Number (Cityville Appeals Office): (833) 555-4000 Fax Number (Appeals Mailing): (877) 555-4001 Fax Number (Texoma RPU Records): 1-877-555-4002 Email (Secure Transmissions): secure-transmissions@nba.gov Website (General): www.nationalbenefitsagency.gov / http://secure.nba.gov Website (Fraud): http://inspector-general.nba.gov/report-fraud

Other: Secure Transmissions Help Desk: 1-866-555-5000

Name: Metro Health & Wellness Center Name Variations: METRO HEALTH & WELLNESS #1, METRO HEALTH & WELLNESS #2, METRO WELLNESS CLINIC,

METRO HEALTH CLINIC, METROWELLNESS GRAND RAPIDS, CLINIC - CENTRAL, METRO HEALTH & WELLNESS, Metro Wellness Office Address (Grand Rapids - Division Ave): 5900 Division Ave S, Ste 120, Grand Rapids MI 49548 Address (Grand Rapids - Wealthy St): 1000 Wealthy St SE, 2nd Fl, Grand Rapids MI 49506 (Zip also listed as 49519 - potential typo) Address (Wyoming): Wyoming, MI (Associated with phone 616-555-7890) Phone Number: 1-888-555-9876 / (616) 555-7890 / 1-616-555-7890 / (616) 456-1234 Fax Number: (616) 456-5000

Associated Providers: Amelia Chen MD-Resident, David S Green MD, Fatima Khan MD, Kevin M Jones PA-C, Sarah Rodriguez MA, Ben Carter DO-Resident, Emily R White NP, Thomas Lee MD, Jessica Brown OTR/L, Michael Davis PT, Olivia Garcia LCSW

Name: Willow Creek Medical Center Address: 789 Oak Street, Springfield, IL 62704 Phone Number: (217) 555-7890 Fax Number: (217) 555-7891 Associated Providers: Dr. Eleanor Vance MD, Dr. Benjamin Carter MD-Resident, Dr. Sophia Chen MD, Nurse Rodriguez RN, Mr. Thomas Evans, Dr. Ahmed Khan MD, Nurse Olivia Green RN, Dr. Isabella Rossi MD, Mr. Michael Lee, Nurse Emily Adams CNP, Dr. Jacob Miller MD-Resident, Mrs. Patricia White PA-C, Dr. David Kim MD, Dr. Chloe Taylor DO-Resident, Dr. Noah Wilson MD, Nurse Grace Foster RN, Mr. Christopher Brown RN, Nurse Ashley Clark RN, Nurse Sarah Harris RN, Ms. Jessica Baker PCA, Mr. Kevin Martinez PT, Nurse Victoria King RN, Mr. Daniel Scott OTR/L, Dr. Samuel Davis MD

Other: Affiliated with Central Illinois Health System

Name: Unity Care Clinic Associated Provider: Elena Petrova, MD Phone Number (Elena Petrova): +1-415-555-0187

Fax Number (Elena Petrova): +1-415-555-0188

Name: Central Plains Medical Center / Prairie General Hospital Address: 789 Oak Avenue, Omaha NE 68102 Phone Number: (402) 555-1212 / 402-555-1234 (Prairie General) Fax Number: 402-555-5678 Associated Providers: Eleanor Rigby MD, Silas Marner MD, Ebenezer Scrooge MD, Jane Eyre RN, Pip Great Expectations,

Elizabeth Bennet CNP, Holden Caulfield MD-Resident, Atticus Finch PA-C, Jay Gatsby MD, Daisy Buchanan RN, Scarlett O'Hara RN, Rhett Butler PCA, Humbert Humbert MD, Katniss Everdeen DO-Resident, Harry Potter MD, Hermione Granger RN, Ron Weasley RN, Neville Longbottom RN, Luna Lovegood, Percy Jackson PT, Annabeth Chase OTR/L, Grover Underwood RN

Tax ID: 987654321 (Central Plains)

Name: Sterling Health Clinic Name Variations: Sterling Health, Sterling Clinic, Sterling Health Clinic - Central, Sterling Health Clinic PLLC Address (Central): 456 Oak Avenue, Columbus, OH 43215 Address (North): 789 Pine Street, Worthington, OH 43085 Address (South): 101 Maple Lane, Grove City, OH 43123 Phone Number (Central): (614) 555-0101 / 1-614-555-0102 Phone Number (North): (614) 555-0202 Phone Number (South): (614) 555-0303 / (614) 555-0304 Fax Number (Central): (614) 555-0199 / 6145550198 Fax Number (South): (614) 555-0399 Associated Providers: Dr. Eleanor Vance MD, Robert Chen PA-C, Sarah Miller LCSW, Dr. Javier Rodriguez MD, Dr. Chloe Kim DO

Other: Associated with Aurora Labs, Greenway Pharmacy, Summit Medical Technologies

Name: Dr. Elias Vance / Vance Medical Group Address (City Center): 456 Elm Street, Suite 300, Metroville, CA 90210 Address (Suburban Clinic): 789 Oak Avenue, Clinic B, Greenfield, CA 90215 Phone Number (City Center): (310) 555-1234 Phone Number (Suburban Clinic): (310) 555-5678 Fax Number (City Center): (310) 555-9012 Specialty: Family Medicine Tax ID: 471234567

Role: Treating Physician / Primary Care

Name: Dr. Emily Carter, MD / EMILY CARTER PEDIATRICS PLLC Address: Maplewood Medical Center, 789 Oak Ave, Suite 201, Springfield, IL 62704

Phone Number: (217) 555-1234 / 217-555-5678

Name: Dr. Eleanor Vance

(No specific contact details provided besides name variation)

Name: Dr. Elara Vance / Elara Vance, Ph.D.

(No specific contact details provided besides name variation)

Name: WELLNESS CONSULTANTS LTD

(No specific contact details provided)

Name: Anya Sharma MD

(No specific contact details provided)

Name: Christopher Thorne PhD

(No specific contact details provided)

Name: RIVER CITY HEALTH CLINIC

(No specific contact details provided)

Name: MediRecords Solutions Inc. Address: PO Box 12345, Dallas, TX 75212 Phone Number: 1-888-555-7890 Email: support@medirecordssolutions.com

Tax ID: 86-7530911

Name: Community Support Integrity Unit Phone Number: (888) 777-8888 / 1-888-777-8888 Phone Number (TTY): (800) 444-5555 / 1-800-444-5555

Website: https://www.communitysupportwatch.org

Name: Arthur Pendragon

Phone Number: (800) 555-0199 (Associated with Avalon Benefits Department)

Name: GREAT LAKES FINANCIAL SERVICES

(No specific contact details provided)

Name: Caring Hands Assistance Group

Address: 456 Maple Ln, Serenity Creek, CA 90210

Name: BRIGHT STAR COMMUNITY SERVICES

Address: 1420 E 48th St, Chicago, IL 60615

Name: Community Support Services LLC

Address: 456 Oak Avenue, Suite 201, Anytown, CA 90210

Name: Zenith Solutions Group Inc.

Address: CHICAGO, IL 60602

Name: GLOBAL IMPORTS LTD.

Address: CHICAGO, IL 60601

Name: Dr. Elias Müller (Berlin Heart Clinic listing) Address: Kaiser-Wilhelm-Allee 10, 12103 Berlin, Germany Phone Number: +49 30 12345678

Other ID: DE9876543210 (Listed under Berlin Heart Clinic)

Name: Maria Rodriguez / MARIA RODRIGUEZ

Associated with: Summit Community Services (Denver, Colorado)

Name: Community Outreach Center of America

Address: Chicago, Illinois

Name: Compassionate Care Support Services

Address: 123 Wellness Way, Detroit, Michigan

Name: Wellness Solutions Group

Address: Phoenix, Arizona

Name: Alliance Care Services

Address: 789 Compass Way, Northwood, Ohio

Name: Community Support Services Inc.

Address: 456 Oak Avenue, Suite 201, Atlanta, GA

Name: Benevolent Aid Services

Address: 789 Welfare Ave, Communityville, CA 90210

Name: Zenith Assurance Group

Address: 100 Horizon Drive, Suite 500, Cityville, ST 98765

Name: Alliance Wellness Solutions

Address: Oak Brook, IL

Name: Anya Sharma, NP / ANYA S SHARMA NP / ANYA N SHARMA NP Phone Number: 555-123-4567 (listed under Metro Health Clinic)

Associated with: City General Hospital, Metro Health & Wellness Center

Name: Dr. Alistair Finch / Alistair Finch MD Role: Lead Physician / Neurologist

Associated with: Maplewood General Hospital, Northwood Neuroscience Center, City Memorial Clinic

Name: David Lee, LSW / LEE, DAVID LSW

Associated with: Community Support Services, Family Wellness Center

Name: Sarah Jenkins RN / SARAH JENKINS RN

Associated with: City General Hospital, Metro Health Center

Name: Seraphina Dubois / SERAPHINA DUBOIS

Associated with: Saint Jude's Wellness Clinic

Name: Dr. Anya Sharma, PhD, LCSW

Associated with: Serenity Mental Wellness Clinic

Name: Arthur Ford RN / FORD RN, ARTHUR

Associated with: Evergreen General Hospital, Riverwood Medical Center

Name: Dr. Elara Vance Phone Number: 555-0101

Associated with: New Leaf Wellness Clinic

Name: Clara Bennett / BENNETT, CLARA

Associated with: St. Jude's Medical Center, Community Health Clinic of Eastside

Name: Eleanor Vance, NP Phone Number: Ext. 4321

Associated with: City General Medical Center

Name: Eleanor Vance, LCSW / VANCE, ELEANOR LCSW

Associated with: Havenwood Community Clinic

Name: Dr. Evelyn Reed MD Phone Number: (555) 123-4567 Ext. 8910

Associated with: Saint Jude's Medical Center

Name: Dr. Elias Thorne / THORNE MD-Physician, ELIAS Phone Number: Extension# 5501

Associated with: Blackwood General Hospital

Name: Dr. Liam O'Connell MD / O'CONNELL MD, LIAM / O'CONNELL

Associated with: Cedar Ridge Hospital

Name: Dr. Elias Thorne MD / THORNE MD, ELIAS

Associated with: St. Jude's Children's Research Center

Name: Anastasia Petrova RN / PETROVA RN, ANASTASIA

Associated with: St. Michael's Medical Center

Name: Mark Anthony Johnson RN / JOHNSON RN, MARK ANTHONY

Associated with: Community Wellness Clinic

Name: Sarah Johnson LCSW / JOHNSON LCSW, SARAH

Associated with: Beacon Street Family Services

Name: Clara Barton RN / BARTON RN,CLARA

Associated with: St. Jude's Community Clinic

Name: Alice Smith PCA

Associated with: Northern Hills Medical Center

Name: Olivia Thompson / THOMPSON, OLIVIA

Associated with: Grace Mercy Community Services

Name: Dr. Elias Thorne Phone Number: (313) 555-9876

Associated with: Metro Wellness Clinic

Name: Robert Miller LCSW / Miller, Robert Phone Number: 555-0123 (Office)

Associated with: Community Health Clinic of Oakwood

Name: Clara Benson RN / BENSON RN, CLARA

Associated with: Mercy General Hospital

Name: Dr. Elias Thorne, PhD, LCSW

Associated with: Willow Creek Mental Wellness Center

Name: Dr. Eleanor Vance, MD Phone Number: +1-585-241-0987 Fax Number: +1-585-365-7890

Associated with: University of Rochester Medical Center

Name: Dr. Sarah Miller PhD

Associated with: Evergreen Health Clinic

Name: Sarah Miller

Associated with: Evergreen Social Services

Name: Eleanor Vance, D.O.

Associated with: Willow Creek Clinic

Name: Dr. Anya Sharma, M.D.

Associated with: Riverbend Health Clinic

Name: Eleanor Vance PhD / VANCE PHD, ELEANOR

Associated with: Community Health Center of Hope

Name: Community Health Clinic of Oakwood

Phone Number: 734-987-6543

Name: City General Hospital Address: 1500 Elmwood Avenue, Metropolis, CA 90210

Phone Number: 555-123-4567

Name: Summit Peak Medical Center

Phone Number: +1-720-555-0189

Name: Oakwood Springs Medical Center

Phone Number: 734-555-0123

Name: Evergreen Physical Therapy & Wellness Phone Number: 503-555-0199

Other: Specializing in Post-Injury Rehabilitation

Name: Community Health Clinic

Phone Number: 555-123-4567

Name: Community Wellness Center

Other ID: 987654321098 (Associated with Dr. Sanjay Patel)

Name: Community Support Advocates Address: 789 Oak Avenue, Anytown, CA 91234 Phone Number: (555) 123-4567

Email: contact@communitysupport.org

Name: Community Support Services Address: 789 Elm Street, Anytown, CA 90210

Phone Number: 5551234567

Name: City Care Pharmacy Address: 101 Elm Street, Anywhere, CA 90210

Phone Number: (555) 123-4567

Name: Aurora Medical Plaza / Imaging Services Address: 789 Oak Avenue, Clearwater, FL 33755 Phone Number: (727) 555-9876 / (727) AURORA1

Fax Number: (727) 555-1234

Name: Compassionate Care Connect

(Client Management System, no specific contact details)

Name: GENESIS DIAGNOSTICS Address: 789 Oak Avenue, Suite B, Rivertown, CA 90210

Phone Number: 800-111-2222

Name: Compassionate Care Alliance / Gentle Hands Services Address (Main): 555 Serenity Lane, Suite 100, Harmony Creek, CA 90210 Address (Mail): P.O. Box 789, Harmony Creek, CA 90211 Phone Number: 800-777-8888 / 310-999-0000 Phone Number (TTY): 711 Fax Number: 310-999-0001 Email: info@gentlehands.org

Website: www.gentlehands.org

Name: Willow Creek Health System

(Associated with Unity Care Network, no specific contact details)

Name: California Department of Social Services (CDSS) Phone Number: 1-800-952-5253

Phone Number (TTY): 1-800-952-8349

Name: Community Outreach and Support Services Alliance Address: 456 Oak Avenue, Suite 300, Anytown, CA 90210

Phone Number: (555) 123-4567

Name: Community Assistance Program Associated Centers: CAP - Central Branch (246 Maple Dr, Metropolis, NY 10001), CAP - Riverside Office (789 River Rd, Metropolis, NY 10002)

Associated with: Department of Human Services

19 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

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

Page 1 of 2 OMB No. 0960-0623

Whose Records to be Disclosed

NAME (First, Middle, Last, Suffix)	Birthday (MM/DD/YYYY)
Arthur Miller	05/21/1965
SSN	
456-12-7890	

AUTHORIZATION TO DISCLOSE INFORMATION TO THE NATIONAL BENEFITS AGENCY (NBA)

\ PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW \ I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT	**THIS BOX TO BE COMPLETED BY NBA/State Agency (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:**
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	

OF WHAT

THIS BOX TO BE COMPLETED BY NBA/State Agency (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

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

OF WHAT

THIS BOX TO BE COMPLETED BY NBA/State Agency (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

All educational sources (schools, teachers records administrators, counselors, etc.)

Social workers/rehabilitation counselors

Consulting examiners used by NBA

Employers, insurance companies, workers' compensation programs

Others who may know about my condition (family, neighbors, friends, public officials)

TO WHOM The National Benefits Agency 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 NBA'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 NBA and my sources to revoke this authorization at any time (see page 2 for details). NBA 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	**IF not signed by subject of disclosure, specify basis for authority to sign**
INDIVIDUAL authorizing disclosure Signature	☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain) (Parent/guardian/personal representative sign here if two signatures required by State law)
Date Signed	**Street Address** 789 OAK AVE
Phone Number (with area code) (773) 555-9876	City CHICAGO
	State ZIP IL 60601

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.

Back to top 20 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024 Form NBA-827 (03-2020)

Page 2 of 2

Explanation of Form NBA-827, "Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 NBA-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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA makes every reasonable effort to ensure that the information in the NBA-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 National Benefits 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 contracts where necessary to establish or verify information provided by representative payees or payee 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.nationalbenefitsagency.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

1. 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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top 21 of 21: 10E: Exhibit List to Rep PH2E - EXHIBITLISTREP Src: Cityville Appeals Office 02/29/2024

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned

RQID:ABCDE12345678901234567890123 45 SITE:Y99 DR:S SSN:\\\\\ DOCTYPE:5032 RF:D CS:k567

Fax Number: (877) 555-4001

Claimant: Arthur Miller

Back to top

1 of 1: 11E: Representative Correspondence - REPLTR Src: Legal Advocates for the Disabled 04/02/2024

Legal Advocates for the Disabled for Arthur Miller XXX-XX-7890

As you are aware, your case was scheduled for a hearing on 05/29/2024 at 10:30 AM. In preparation for the upcoming hearing we have ordered medical evidence, listed below, based on the information you provided to our office. If we are missing any treatment facilities, please contact the office immediately.

Provider	From	To	Requested	Received
Sterling Health Clinic	7/7/2023	present	4/1/2024	
Sterling Health Clinic	Physical RFC		4/1/2024	
Central Plains Medical Center	2/10/2023	present	4/1/2024	
Metro Health & Wellness Center	4/14/2023	present	4/1/2024	
Metro Health & Wellness Center	Physical RFC		4/1/2024	

CC: Appeals Division via Secure Transmissions, in compliance with 5-day Rule.

Back to top

1 of 2: 12E: Resume of Vocational Expert - VERESUM Src: MARIA RODRIGUEZ 05/14/2024

Maria Rodriguez, MS,CRC,CDMS,CCM Vocational Consultant

Qualifications:

- Over thirty years of experience in vocational evaluations and job placement services with adults who were injured on the job, in vehicle accidents, or disabled due to long term illnesses
- Vocational test administration and interpretation
- Transferable skills analysis and development of new job goals
- Job seeking skills training, job search preparation, and identification of resources
- Outreach to employers regarding employment requirements, job analysis and workplace accommodations

Education: Master of Science in Vocational Rehabilitation with a Specialty in Work Evaluation State University of the Plains – Springfield, Kansas

Bachelor of Arts in Psychology and Sociology Prairie View College Centerville, Iowa

Certifications: Certified Rehabilitation Counselor (CRC) 00001234 Certified Disability Management Specialist (CDMS) Certified Case Manager (CCM)

Work Experience: Community Outreach Center of America Chicago, Illinois 2018 to current Vocational Consultant

Compassionate Care Support Services 123 Wellness Way, Detroit, Michigan 2001 – 2018 Sr. Vocational Consultant

National Benefits Agency Appeals Division 2014 to current Vocational Expert

Wellness Solutions Group, and Alliance Care Services 789 Compass Way, Northwood, Ohio 2000 - 2001 Vocational Consultant, Contractual

Community Support Services Inc. 456 Oak Avenue, Suite 201, Atlanta, GA 1989 – 2000 Sr. Vocational Consultant

Benevolent Aid Services (Travelers Insurance Co.) 789 Welfare Ave, Communityville, CA 90210 1988 – 1989 Vocational Consultant

Zenith Assurance Group 100 Horizon Drive, Suite 500, Cityville, ST 98765 1986 - 1988 Vocational Case Manager

Back to top 2 of 2: 12E: Resume of Vocational Expert - VERESUM Src: MARIA RODRIGUEZ 05/14/2024

Alliance Wellness Solutions Oak Brook, IL 1980 – 1986 Vocational Supervisor/ Vocational Consultant

Back to top

1 of 1: 13E: Correspondence regarding efforts to obtain evidence - EALTR Src: OHO 05/20/2024

Legal Advocates for the Disabled for Arthur Miller XXX-XX-7890

Dear Judge,

In preparation for the hearing scheduled for 05/29/2024 at 10:30 AM our office has ordered records from the medical facilities listed below. We have submitted the records we have received and will submit any outstanding records as soon as they are received. Please accept this as notification in compliance with 81 Fed. Reg. 90987.

Provider	From	To	Requested	Received	Submitted
Sterling Health Clinic			Physical RFC	4/1/2024	
4/3/24 Rcvd fax from facility. C has appt on 4/3 @ 9:45 for physical. Form will be completed and sent over after. ASC					

Legal Advocates for the Disabled for Arthur Miller XXX-XXX-7890

RECORDS OBTAINED AND READY FOR USE FOR Arthur Miller (SSA
Hearing Date: 05/29/2024

Provider	From	To	Requested	Received	Submitted	Notes
Sterling Health Clinic			Physical RFC	4/1/2024		4/3/24 Rcvd fax from facility. C has appt on 4/3 @ 9:45 for physical. Form will be completed and sent over after. ASC 4/29/24 Called fac spoke w/Sarah and c was a NO SHOW for appt. And he didnt reschedule appt, I

Provider	From	To	Requested	Received	Submitted	Notes
						will email SAM/ ASC to review.VS
Sterling Health Clinic	7/7/2023	present	4/1/2024	04/19/2024	05/20/2024	
Central Plains Medical Center	2/10/2023	present	4/1/2024	No Records		4/8/24 Email from MediRecords Solutions Inc. ereq #188937708 for $30.60. Sent NO RECS statement to SAM/MR backup folders. Will email Datavant about adj.VS
						4/15/24 Email from Monishar D (Datavant) inv submitted for adj to $0. And allow 1-3 business days to be completed.VS
Metro Health & Wellness Center	4/14/2023	present	4/1/2024	No Records		4/9/24 Email from MediRecords Solutions Inc. ereq #188937318 for $30.60. Sent NO RECS statement to SAM/MR backup folders. Will email Datavant about adj.VS
Anya Sharma, NP						4/15/24 Email from Shannon J (Datavant) inv

Provider	From	To	Requested	Received	Submitted	Notes
						submitted for cancellation. And to allow 1-3 business days to be reviewed.VS
Metro Health & Wellness Center			Physical RFC	4/1/2024		4/9/24 Must contact facility directly for form to be completed, but there are no recs from DOS requested from 4/14/23 to p, so not sending form to facility since C has not been there in a year. ASC

Anya Sharma, NP

CC: Arthur Miller

Notice for Exception of Processing
Request for Medical Records

Date: 01/16/2023 Patient: Arthur Miller

Attention Requestor: We have received your request for copies of medical records on the above referenced patient. We are unable to complete processing of your request for the following reason(s):

[ ] We have no record of treatment for the above referenced patient. [ ] We have no record of treatment for the date(s) of service you request. [x] Due to their age, the records you have requested have been destroyed in accordance with state and federal destruction guidelines. This record no longer exists. [ ] A HIPAA compliant authorization was not included in your request. Please re-submit the attached HIPAA release/authorization form once completed by the patient. [ ] The records you have requested contain "sensitive & highly confidential" information. This information may be released via specific written consent from the patient. Please find the attached "Authorization to Release Sensitive Information Form". [ ] The Medical Records Department is not responsible for completing forms or responding with narratives. If you wish to obtain copies of medical records, please submit a written request with a valid authorization. Please be advised that there may be a charge for this service.

The HIPAA Authorization submitted lacks one or more of the following required elements:

[ ] Identification of the patient (name, date of birth, or social security number) [ ] A Description of the information to be disclosed must appear in the request. [ ] An explanation/reason of the disclosure must be stated. [ ] The notification statement pertaining to the individual's right to revoke authorization was missing from your request. [ ] The notification statement pertaining to the potential for disclosed information to be re-disclosed by recipient was missing from your request. [ ] The form must identify the person or entity authorized to release the PHI. [ ] The form must identify those person(s) authorized to obtain/receive the PHI. [ ] The form must be signed and dated by the patient or documented representative. (Documentation must be present with request/authorization.) [ ] The patient is deceased. A Death Certificate, Affidavit of Relationship, or Letter of

Administration/Testament must accompany the request. [ ] The form must provide a date of expiration. [ ] We are unable to release records to a 3rd party requestor. A Letter of Representation must accompany your request. [ ] Please provide an authorization with an updated signature and date. (Signature must be subsequent to the last treatment date requested.) [ ] Other-

Please re-submit your request with the appropriate documentation

---

12A3B4C5D6E7F8G9H0I1, MILLER, 11

Back to top 2 of 6: 1F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #1 01/16/2023 From: Internal Processing

To:, Page 5/9 Page: 06 of 11 2023-01-18 15:01:15 EST 18885559876

01.12.2023 13:52:29 National Benefits Agency

NATIONAL BENEFITS AGENCY NBACD Texoma Records Processing Unit PO Box 5001 New Town, KY 40701-0002

CLINIC - CENTRAL December 28, 2022 METRO HEALTH & WELLNESS 5900 DIVISION AVE S STE 120 GRAND RAPIDS MI 49548

[Barcode Placeholder] ROID:R0198765400055887002_ SITE:TXM RN:A SSN: DOCTYPE:0002 RF:E CS:nbba

SSN: XXX-XX-7890

Claimant: ARTHUR MILLER

This page must be on top of your records. Slide this page into the return window envelope with this Texoma Records Processing Unit address showing. --> --> New Town, KY 40701-0002

PO Box 5001

PLEASE NOTE: NBA has contracted with a specialized vendor to scan your medical records before they are sent to the DAS. Therefore, your response must be sent to the address as indicated above and in the box to the right. Do NOT send your records directly to the DAS.

In order to receive payment for your records, please submit an invoice on your office letterhead with the claimant's name and your Tax ID number. THE INVOICE MUST BE PLACED BEHIND THIS BAR CODED PAGE.

TO EXPEDITE YOUR RESPONSE FAX RECORDS TO: 1-877-555-4002

If you are sending records for more than one individual, you may place all of the records in the same envelope, or fax them at the same time. However, you must put the barcode page for each individual on TOP of THEIR own individual records.

To send us records electronically go to NBA's free, secure website address at: http://secure.nba.gov. Use the 3 character site code from the barcode as the destination for sending the records.

To register for access or for additional information, call the National Benefits Agency Secure Transmissions Help Desk at 1-866-555-5000 or send them an email at secure-transmissions@nba.gov

NBF-AB2-2 NBF AB2 (09/20) NB To,

NATIONAL BENEFITS AGENCY Texoma Records Processing Unit PO Box 5001, New Town, KY 40701-0002

December 28, 2022

CLINIC - CENTRAL METRO HEALTH & WELLNESS 5900 Division Ave S Ste 120 Grand Rapids MI 49548 Page: 07 of 11 2023-01-18 15:01:15 EST 18885559876 From: Production Primary

```
01.12.2023 13:52:58 National Benefits Agency
```

RE: ARTHUR MILLER AKA: SSN: XXX-XX-7890 DOB: 05/21/1965 NBA CASE NUMBER: 987654 CONTRACT NUMBER: 447443

The above-named individual has applied for disability benefits under the National Benefits Act. I would appreciate your sending a copy of the individual's medical records covering the dates listed below. A narrative report or copies of your records are equally satisfactory. A copy of the individual's consent for release of this information is enclosed.

IDENTIFYING INFORMATION:

Dates of Treatment: 07/01/2021 TO CURRENT Patient No:

Alleged Impairments: CAR ACCIDENT INJURIES; INSOMNIA; BODY NUMBNESS; HIP, NECK, BACK PROBLEMS; LEARNING DISABILITY

Please include the following information in your report:

1. History of the impairment(s);
2. Objective clinical findings including office notes, exams, psychological tests, and special studies;
3. Diagnosis and prognosis based on medical findings;
4. An assessment of functional ability based on your medical findings.

If, after review of your report, specific information is needed which is unavailable from other sources, we may need to purchase a consultative examination. If you would be willing to perform such an examination on your patient for us at a reasonable fee, please indicate YES _ ***NO*** _.

Requesting Payment for Medical Reports

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Benefits Assessment Division in your state.

MEF-IP1-1 MEF/IP1 (07/15) DA

Back to top 4 of 6: 1F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #1 01/16/2023 To:, Page: 08 of 11 2023-01-18 15:01:15 EST 18885559876 From: Production Primary 01.12.2023 13:53:19 National Benefits Agency Page 7/9

If payment is required for the medical records, you must send us an invoice that includes your UEI number with the medical records. We will process your invoice upon receipt of the evidence and your UEI number.

Your prompt response will help assure a speedy decision on this claim. Thank you for your cooperation.

PLEASE RETURN A COPY OF THIS LETTER WITH YOUR RESPONSE.

J. Evans Disability Examiner (972) 555-0100,

__THIS REQUEST IS BEING RETURNED. WE DO NOT HAVE THE INFORMATION

REQUESTED.

Physician's signature

MEF-IP1-1 MEF/IP1 (07/15) DA 5 of 6: 1F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #1 01/16/2023

To:, Page: 09 of 11 2023-01-18 15:01:15 EST 18885559876 From: Production Primary

01.12.2023 13:53:29 National Benefits Agency Page 8/9

NATIONAL BENEFITS AGENCY

Requesting Payment for Medical Records

The National Benefits Agency (NBA) pays for medical records or photocopies according to the fee schedule approved by the Disability Determination Services of the state in which the claimant resides.

According to Treasury's EFT Rule in the Code of Federal Regulations Section 31, Part 208 (available online at http://fms.treas.gov/eft/index.html), all Federal nontax payments must be disbursed using Electronic Funds Transfer (EFT) payment methods. Therefore, vendors are required to register in the System for Award Management (SAM). Providing EFT information, such as banking information, ensures that payments reach vendors in a secure and timely manner. By enrolling in SAM, NBA will automatically receive any information updates a vendor makes in SAM. You are encouraged to register in SAM now in anticipation of the change to EFT payments. Registration in SAM is free of charge.

If you have not already registered in SAM to receive your payments electronically, please see the instructions below. Step 1: Prepare to register in SAM by locating your Taxpayer Identification Number (TIN), your business location, and your banking information. Step 3: Access SAM at https://www.sam.gov/portal/public/SAM/. Step 4: Create a SAM User Account if you do not already have one. Step 5: Register your Entity. During your registration, you may obtain your Unique Entity ID (UEI). Step 6: Remain in an 'active status' and update your information as needed.

For any questions regarding registration, please contact SAM Customer Service at Federal Service Desk (www.fsd.gov)

Hours: 8am - 8pm (Eastern Time) US Calls: 866-606-8220 International Calls: 334-206-7828

How to Request Payment

When requesting payment, please submit a completed copy of the Medical Evidence of Record Billing Invoice that was included with the original medical evidence request. You also have the option of submitting your own invoice on your office letterhead. Please remember to

MEF-IP1-1 MEF/IP1 (07/15) DA 6 of 6: 1F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #1 01/16/2023

To:, Page: 10 of 11 2023-01-18 15:01:15 EST 18885559876 From: Production Primary Page 9/9

01.12.2023 13:54:03 National Benefits Agency include Arthur Miller's name, the contract number, your Tax ID number, your current address, and your DUNS number.

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Benefits Adjudication Office in your state; however, as a federal program we are exempt from paying state sales tax.

How to Get Payment Information

To obtain information on how to contact NBA regarding a vendor payment, please visit http://www.nationalbenefitsagency.gov/vendor/contact.htm. If you are enrolled in the Financial Services Gateway (FSG), please visit www.fsg.gov to obtain vendor payment information. You can access FSG with your user ID and password to receive the status of your payments for the past 30 days. Information is available as of the payment date. FSG will provide the invoice number, payment amount, and payment date. In addition, you can request an email notification when payment data is available on the FSG website.

Thank you for your participation!

MEF-IP1-1 MEF/IP1 (07/15) DA 0901001006004r Back to top

1 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023 MILLER, ARTHUR - C-987654321

Orthopedics Clinic Note Final Report

Result type: Orthopedics Clinic Note Result date: October 01, 2022 09:00 EDT Result status: Auth (Verified) Result title: Metro Wellness Office Visit Note Performed by: LEE, DAVID LSW on October 01, 2022 09:15 EDT Verified by: FINCH, ALISTAIR MD on October 08, 2022 11:30 EDT Encounter info: 987654321098, AMB DR ORTDHQ, Amb Outpatient-Active Chgs, 10/01/2022 - 10/10/2022

Final Report

Patient Demographics

Patient Name: MILLER, ARTHUR Birth Date: 05/21/1965 Age: ~57 years Gender: Male Date of Service: 10/01/2022 10:30 Referring Physician: VANCE MD, ELIAS

Patient Demographics

Patient Name: MILLER, ARTHUR Birth Date: 05/21/1965 Age: ~57 years Gender: Male Date of Service: 10/01/2022 10:30

Problem List/Past Medical History

Ongoing No qualifying data Historical No qualifying data

Procedure/Surgical History

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with o (11/29/2019), Administration of diphtheria-tetanus- pertussis, combined (07/10/2011).

Medications

acetaminophen 500 mg oral tablet, disintegrating, 1 Tab, By Mouth, Q6, PRN

Allergies

No Known Allergies

Social History

Alcohol - Denies Alcohol Use Substance Abuse - Denies Substance Abuse Tobacco - Denies Tobacco Use Never smoker

Printed by: DUBOIS, SERAPHINA Printed on: 2/15/2023 07:00 EST Page 1 of 3 Back to top 2 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023 MILLER, ARTHUR - C-987654321 Orthopedics Clinic Note Final Report

Referring Physician: VANCE MD, ELIAS

Chief Complaint rthip

History of Present Illness Patient is a 50 year-old male who is presenting as a new patient with chronic R hip pain. Today, patient resting in a chair without distress. Patient has known arthritic changes noted in their R hip. Patient complaining of pain. Rates the pain as 8/10 and dull and achy in nature, with radiation to groin and buttock region. Pain is improved by rest. Pain is worsened by weight bearing activities such as standing, prolonged ambulation, and going up and down the stairs. Patient has attempted conservative treatment in the form of NSAIDs with mild relief. Has not attempted PT or Injections. Patient states he was in a MVC in 2012 and has had hip pain since then. However, the pain has worsened over the past two years. No recent acute events. Denies recent falls or injuries. Has been ambulating without assistive devices. Pain tolerated at baseline. Patient denies fever, chills, chest pain, shortness of breath, nausea, vomiting, weakness, tingling sensation, numbness, or any other joint pain. Interested in PT.

Physical Exam Vitals & Measurements HR: 94 (Monitored) BP: 126/86 WT: 69.85 kg BMI: 24.9 Pain Assessment: Pain Score (Activity) : 09/15/2022 13:00 8

Adult Pain Scale : 09/15/2022 13:00 VAS

General Appearance: Well-nourished, well developed in no acute distress Orientation: Oriented to person, place and time. Mood / Affect: Calm Gait: normal Coordination: normal

Hip Exam (Bilateral) Inspection / Palpation LE (R/L): TTP over Greater trochanter of R Hip R HIP: + FADIR, + FABER, +LOGROLL Hip Flexion (R/L): 120° / 120° Hip Extension (R/L): 20° / 20° Hip Adduction (R/L): 15° / 15° Hip Abduction (R/L): 40° / 40°

Hip IR (R/L): 5° / 5° Hip ER (R/L): 30° / 30° Strength LE: 5/5 EHL, tibialis anterior, plantar flexion bilaterally Sensation: Subjective normal distal sensation bilaterally Vasculature: 2+ dorsalis pedis pulse bilaterally LE Skin: no rashes or lesions bilaterally Lymph LE: no inguinal lymphadenopathy DTR LE: Patellar (2+/2+); Achilles (2+/2+)

Diagnostic Studies XRAY HIP and PELVIS RIGHT DATE: 9/15/222 Severe subchondral sclerosis, and cystic changes in femoral head likely AVN.

Assessment/Plan

1. Avascular necrosis of bone of right hip 50 YO M with R Hip pain

Likely AVN based on radiographs Patient wants to try PT before considering further surgical options NSAIDs for pain relief Follow up as needed Ordered: Evaluation and Treatment (PT) - AMB

Orders: acetaminophen, = 1 Tab, By Mouth, Q6, PRN as needed for pain, # 50 Tab, 0 Refill(s) Diagnosis: M87.051 Idiopathic aseptic necrosis of right femur

I saw and evaluated the patient with the Resident, and I reviewed and discussed the case with the Resident and agree with the Resident's findings and plans as documented above. on9/15

Completed Action List: Perform by LEE, DAVID LSW on September 15, 2022 13:21 EDT Modify by LEE, DAVID LSW on September 15, 2022 14:02 EDT Sign by LEE, DAVID LSW on September 15, 2022 14:02 EDT Requested by LEE, DAVID LSW on September 15, 2022 13:21 EDT Modify by LEE, DAVID LSW on September 15, 2022 14:03 EDT Sign by LEE, DAVID LSW on September 15, 2022 14:03 EDT Modify by FINCH, ALISTAIR MD on September 22, 2022 10:05 EDT Sign by FINCH, ALISTAIR MD on September 22, 2022 10:05 EDT Requested by LEE, DAVID LSW on September 15, 2022 14:03 EDT VERIFY by FINCH, ALISTAIR MD on September 22, 2022 10:05 EDT

Back to top 4 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023

MILLER, ARTHUR - C-987654321

Assessment Notes \ Final Report \

Result type: Assessment Notes Result date: January 18, 2023 07:58 EST Result status: Modified Result title: Perioperative Screening Performed by: Jenkins RN, Sarah on January 18, 2023 07:58 EST Verified by: Jenkins RN, Sarah on January 18, 2023 07:58 EST Encounter info: 987654321098, CENTRAL PLAINS MEDICAL CENTER, PreRegistration-Outpatient

\ Final Report \ Document Has Been Revised

Perioperative Screening Entered On: 1/18/2023 07:59 EST
Performed On: 1/18/2023 07:58 EST by Jenkins RN, Sarah

Travel History / Infectious Symptoms Contact Outside US/Canada 30 Days: No or no contact with recent traveler Healthcare Outside US within Last Year: No Ebola - Any symptoms?: No Jenkins RN, Sarah - 1/18/2023 08:04 EST

General I Information Given By: Patient, Patient Record, Phone Jenkins RN, Sarah - 1/18/2023 08:04 EST Living Situation: Home independently Jenkins RN, Sarah - 1/18/2023 08:04 EST Mobility Assistance Prior to Admission: Partial assistance Religious Preference: Muslim

COVRP Birth: Denies Jenkins RN, Sarah - 1/24/2023 13:43 EST {[Denies] - previously charted by Jenkins RN, Sarah at 1/18/2023 08:26 EST); {[Denies] - previously charted by Jenkins RN, Sarah at 1/18/2023 08:04 EST); Caregiver Gender: Denies Death: Denies Diet: Yes, No Pork Dying: Denies Holy Days: Denies Pain Management: Denies Blood Products: Denies Placenta: Denies Jenkins RN, Sarah - 1/18/2023 08:04 EST

Back to top 5 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023

Assessment Notes MILLER, ARTHUR - W-987654321 Final Report

Surgical Procedure Desc: Right total hip arthroplasty 1/30/2023 at 0830 hrs

PAT 01/24/2023 at 1000 hrs (No Show)

PAT scheduled 2nd time for 1/26 at 0800 hrs JENKINS RN, SARAH - 1/24/2023 13:43 EST {[Right total hip arthroplasty 1/30/2023 at 0830 hrs

PAT b1/24/2023 at 1000 hrs] - previously charted by JENKINS RN, SARAH at 1/18/2023 08:26 EST}; {[Right total hip arthroplasty 1/30/2023 at 0830 hrs] - previously charted by JENKINS RN, SARAH at 1/18/2023 07:58 EST);

Primary Care Physician: Dr. Vance, Elias JENKINS RN, SARAH - 1/18/2023 07:58 EST (310) 555-5678 Pregnancy Status: N/A male Lactation: N/A

General II JENKINS RN, SARAH - 1/18/2023 08:04 EST Preferred Communication Mode: Verbal Languages: English Ability to Read/Write: Able to read, Able to write Education Level: High school Sensory Deficits: Other: Reading glasses Anticipated Communication Barriers: Other: none Surgery Date/Time/Location Reviewed: Yes

Primary Contact JENKINS RN, SARAH - 1/18/2023 08:04 EST Primary Contact Person: Seraphina Dubois (Friend) Primary Contact Mobile Phone Number: 555 555-0102 Alternate Contact Person: Clara Bennett Alternate Contact's Relationship to Pt: Niece/Nephew Alternate Contact Mobile Phone Number: 555 555-0103

Advance Directive JENKINS RN, SARAH - 1/18/2023 08:04 EST Ped Patient and Non-Emancip. Minor: No Advanced Directives (If Applicable): No

Primary Pain Primary Pain Location: Hip Primary Pain Laterality: Right Adult Pain Scale: VAS Pain Score (Rest): 10 Pain Score (Activity): 10 Primary Pain Time Pattern: Constant Primary Pain Quality: Aching, Sharp Primary Pain Radiation: No Primary Pain Interventions: Repositioning

Back to top 6 of 19: 2F: Hospital Records - HOSPITAL Src: Willow Creek Medical Center 10/20/2023 - 02/25/2024

Assessment Notes MILLER, ARTHUR - C-987654321 \ Final Report \

Primary Pain Aggravating Factors : None Primary Pain Alleviating Factors : Repositioning Associated Symptoms : None Pain Negatively Impacts : Daily life JENKINS RN, SARAH - 2/25/2024 09:15 EST

Measurements Height Mode : Stated Height : 170 cm(Converted to: 5 ft 7 in) Weight Mode : Stated Weight : 72 kg(Converted to: 158 lb 12 oz) Height/Length : Height Body Surface Area : 1.8315 BSA Mosteller : 1.8439 JENKINS RN, SARAH - 2/25/2024 09:15 EST

Image 4 - Images currently included in the form version of this document have not been included in the text rendition version of the form. Allergies (As Of: 2/25/2024 09:20:00 EST)

Allergies (Active) No Known Allergies Estimated Onset Date: Unspecified ; Created By: FORD RN, ARTHUR; Reaction Status: Active; Category: Drug; Substance: No Known Allergies ; Type: Allergy ; Updated By: FORD RN, ARTHUR; Reviewed Date: 3/10/2022 10:30 EST

Immunization History Flu Shot : No JENKINS RN, SARAH - 2/25/2024 09:15 EST

Anesth/Transfusion Anesthesia/Transfusions : Prior anesthesia Family History Anesthesia Problem Peds : No Dentition Problems : Missing, Other. 4 upper missing, 1 upper chipped JENKINS RN, SARAH - 2/25/2024 09:15 EST

Prosthetics/Implantable/Medication Device Prostheses/Medical Devices : None Medical Devices : None JENKINS RN, SARAH - 2/25/2024 09:15 EST

Education Education History Results : No education data available. JENKINS RN, SARAH - 2/25/2024 09:35 EST

Preprocedure Education Grid

Procedure Type : Preop	
Education Topics	Family instructions, Infection prevention, Leave valuables at

	home, Medication instructions, Pain management, Preprocedure diet, Spoke with patient/family about concerns, Surgery date/time/location reviewed
Individuals Taught	Patient
Barriers to Learning	None
Teaching Method	Printed materials, Teach Back, Telephone
Learning Response / Teaching Evaluation:	Met
Comment	(Comment: Heart hospital Preop # given [JENKINS RN, SARAH - 1/18/2023 08:26 EST]) JENKINS RN, SARAH - 1/18/2023 08:26 EST

CSSRS Pre-Screener Patient is 12 Years of Age or Older: Yes Suicide Presents Sign and/or Symptoms: No Suicide Presents BH Complaint: No JENKINS RN, SARAH - 1/18/2023 08:26 EST

Completed Action List: Perform by JENKINS RN, SARAH on January 18, 2023 07:58 EST Sign by JENKINS RN, SARAH on January 18, 2023 07:58 EST VERIFY by JENKINS RN, SARAH on January 18, 2023 07:58 EST Modify by JENKINS RN, SARAH on January 18, 2023 08:04 EST Sign by JENKINS RN, SARAH on January 18, 2023 08:04 EST Modify by JENKINS RN, SARAH on January 18, 2023 08:26 EST

Assessment Notes MILLER, ARTHUR - C-987654321 Final Report

Sign by JENKINS RN, SARAH on January 18, 2023 08:26 EST Modify by JENKINS RN, SARAH on January 24, 2023 13:43 EST Sign by JENKINS RN, SARAH on January 24, 2023 13:43 EST

Back to top 9 of 19: 2F: Hospital Records - HOSPITAL Src: Willow Creek Medical Center 09/15/2022 - 01/18/2023

Hip W/Pelvis 2 or 3 Views-Rt PT Name Arthur, Miller - D-841057251 Hip W/Pelvis 2 or 3 Views-Rt PT Name Arthur, Miller - C-987654321 Final Report

Result type: Hip W/Pelvis 2 or 3 Views-Rt Result date: September 15, 2022 12:34 EDT Result status: Auth (Verified) Result title: Hip W/Pelvis 2 or 3 Views-Rt Performed by: ABUJUDEH MD, HANI on September 15, 2022 12:34 EDT Performed by: Dr. Anya Sharma, PhD, LCSW on September 15, 2022 12:34 EDT Verified by: ABUJUDEH MD, HANI on September 15, 2022 12:47 EDT Verified by: Dr. Anya Sharma, PhD, LCSW on September 15, 2022 12:47 EDT Encounter info: 680016671157, AMB DR ORTDHQ, Amb Outpatient-Active Chgs, 09/15/2022 - 09/25/2022 Encounter info: 987654321098, AMB DR ORTDHQ, Amb Outpatient-Active Chgs, 09/15/2022 - 09/25/2022

Final Report

Reason For Exam Pain

DX Report Hip W/Pelvis 2 or 3 Views-Rt: 9/15/2022 11:30 AM

CLINICAL HISTORY: 50 years old Male with Pain CLINICAL HISTORY: 58 years old Male with Pain

TECHNIQUE: Frontal view of the pelvis and 2 views of the right hip

COMPARISON: None

FINDINGS: There is diffuse osteopenia.

Moderate arthritic changes are noted in the left hip with increased sclerosis in the superior aspect of the joint and subchondral cyst formation.

Severe arthritic changes are noted in the right hip with increased sclerosis decreased joint space and subchondral cyst formation, and the femoral head is a geographic sclerotic line, AVN cannot be excluded, an MRI may be helpful for further evaluation and/or CT

IMPRESSION: Severe arthritic changes in the right hip, AVN cannot be excluded, recommend further evaluation with CT and/or MRI if clinically indicated

Signature Line FINAL Dictated By: And Verified By: ABUJUDEH MD, HANI And Verified By: Dr. Anya Sharma, PhD, LCSW

Electronically Signed Date: 09/15/22 12:47 Date Transcribed: PWS 09/15/22 12:34

Hip W/Pelvis 2 or 3 Views-Rt Final Report MILLER, ARTHUR - C-987654321

40705 This document has an image

Completed Action List: Order by FINCH, DR. ALISTAIR on September 15, 2022 12:08 EDT Perform by CAVATAIO RT, ERIN on September 15, 2022 12:34 EDT VERIFY by SHARMA, DR. ANYA, PHD, LCSW on September 15, 2022 12:47 EDT VERIFY by SHARMA, DR. ANYA, PHD, LCSW on September 15, 2022 12:47 EDT

Printed by: DUBOIS, SERAPHINA Printed on: 1/25/2023 06:48 EST Page 2 of 2

Back to top 01.19.2023 12:30:58 National Benefits Agency HelpDesk#:8775552000 Page 1/8

NATIONAL BENEFITS AGENCY SOF TEXOMA Records Processing Unit STOLOS PO Box 5001 New Town, KY 40701-0002

WILLOW CREEK MEDICAL CENTER January 19, 2023 789 OAK STREET SPRINGFIELD IL 62704

ROID:D0987654000448620003 SITE:SØF DR:S SSN: DOCTYPE:0001 RF:D CS:b679

SSN: XXX-XX-7890 Claimant: ARTHUR MILLER

This page must be on top of your records. Slide this page into the return window envelope with this address showing SOF TEXOMA Records Processing Unit PO Box 5001 New Town, KY 40701-0002

PLEASE NOTE: NBA has contracted with a specialized vendor to scan your medical records before they are sent to the Divisions. Therefore, your response must be sent to the address as indicated above and in the box to the right. Do NOT send your records directly to the Divisions.

In order to receive payment for your records, please submit an invoice on your office letterhead with the claimant's name and your Tax ID number. THE INVOICE MUST BE PLACED BEHIND THIS BAR CODED PAGE.

TO EXPEDITE YOUR RESPONSE FAX RECORDS TO: 1-877-555-4002

If you are sending records for more than one individual, you may place all of the records in the same envelope, or fax them at the same time. However, you must put the barcode page for each individual on TOP of THEIR own individual records.

To send us records electronically go to NBA's free, secure website address at: http://secure.nba.gov. Use the 3 character site code from the barcode as the destination for sending the records.

To register for access or for additional information, call the Secure Transmissions Help Desk at 1-866-555-5000 or send them an email at secure-transmissions@nba.gov

MEF-IPL-1 MEF IP1 (07/15) DA MediRecords Solutions Inc. PO Box 12345 Dallas, TX 75212 Tax ID# 86-7530911 12 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023

MediRecords Solutions Inc. PO Box 12345, Dallas, TX 75212 Tax ID: 86-7530911 1-888-555-7890

Ship to: NBA NBA TEXOMA RPU Floor 3, 99 Downtown Blvd Texoma, TX 75001

MediRecords SOLUTIONS INVOICE

Bill to: NBA NBA TEXOMA RPU Floor 3, 99 Downtown Blvd Texoma, TX 75001

Invoice #: 0401686222 Date: 01/25/2023 Customer #: 1381577

Records from: CENTRAL PLAINS MEDICAL CENTER 789 OAK AVENUE OMAHA, NE 68102

Requested By: RPU TEXOMA AGENCY Patient Name: ARTHUR MILLER

CONTRACT NUMBER 448620

Description	Quantity	Unit Price	Amount
Basic Fee			15.00
Retrieval Fee			0.00
Per Page Copy (Paper)	1 10	0.00	0.00
Shipping			0.00
Subtotal			15.00
Sales Tax			0.00
Invoice Total			15.00
Balance Due			15.00

Terms: Net 30 days Please remit this amount : $15.00(USD)

----------✂----------

MediRecords Solutions Inc. PO Box 12345, Dallas, TX 75212 Tax ID: 86-7530911 1-888-555-7890

Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://secure.medirecordssolutions.com/delivery

Please return stub with payment. Please include invoice number on check. To pay invoice online, please go to https://pay.medirecordssolutions.com/ or call 888-555-7890. Email questions to support@medirecordssolutions.com.

Invoice #: 0401686222

Check # _ Payment Amount $_

Back to top

NATIONAL BENEFITS AGENCY SOF TEXOMA Records Processing Unit STOLOS PO Box 5001

New Town, KY 40701-0002

January 19, 2023

WILLOW CREEK MEDICAL CENTER 789 OAK STREET SPRINGFIELD, IL 62704 RE: ARTHUR MILLER AKA: SSN: XXX-XX-7890 DOB: 05/21/1965 DDS CASE NUMBER: 987654 CONTRACT NUMBER: 555987

The above-named individual has applied for disability benefits under the Social Security Act. I would appreciate your sending a copy of the individual's medical records covering the dates listed below. A narrative report or copies of your records are equally satisfactory. A copy of the individual's consent for release of this information is enclosed.

IDENTIFYING INFORMATION:

Dates of Treatment: 07/01/2021 TO CURRENT Patient No:

Alleged Impairments: CAR ACCIDENT INJURIES; INSOMNIA; BODY NUMBNESS; HIP, NECK, BACK PROBLEMS; LEARNING DISABILITY

Please include the following information in your report:

1. History of the impairment(s);
2. Objective clinical findings including office notes, exams, psychological tests, and special studies;
3. Diagnosis and prognosis based on medical findings;
4. An assessment of functional ability based on your medical findin

If, after review of your report, specific information is needed which is unavailable from other sources, we may need to purchase a consultative examination. If you would be willing to perform such an examination on your patient for us at a reasonable fee, please indicate YES _ NO _ .

Requesting Payment for Medical Reports

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Benefits Eligibility Services in your state.

ABC-XYZ-1 ABC/XY1 (07/20) NB 01.19.2023 12:32:07 National Benefits Agency HelpDesk#:8775552000 Page 3/8

If payment is required for the medical records, you must send us an invoice that includes your UEI number with the medical records. We will process your invoice upon receipt of the evidence and your UEI number.

Your prompt response will help assure a speedy decision on this claim. Thank you for your cooperation.

PLEASE RETURN A COPY OF THIS LETTER WITH YOUR RESPONSE.

J. Smith Disability Examiner (555) 555-0101,

THIS REQUEST IS BEING RETURNED. WE DO NOT HAVE THE INFORMATION REQUESTED.

Physician's signature

MET-IP1-1 MEF/IP1 (07/15) DA 15 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023

01.19.2023 12:32:23 National Benefits Agency HelpDesk#: 877-555-2000 Page 4/8

NATIONAL BENEFITS AGENCY

Requesting Payment for Medical Records

The National Benefits Agency (NBA) pays for medical records or photocopies according to the fee schedule approved by the Disability Determination Services of the state in which the claimant resides.

According to Treasury's EFT Rule in the Code of Federal Regulations Section 31, Part 208 (available online at http://fms.treas.gov/eft/index.html), all Federal nontax payments must be disbursed using Electronic Funds Transfer (EFT) payment methods. Therefore, vendors are required to register in the System for Award Management (SAM). Providing EFT information, such as banking information, ensures that payments reach vendors in a secure and timely manner. By enrolling in SAM, NBA will automatically receive any information updates a vendor makes in SAM. You are encouraged to register in SAM now in anticipation of the change to EFT payments. Registration in SAM is free of charge.

If you have not already registered in SAM to receive your payments electronically, please see the instructions below.

Step 1: Prepare to register in SAM by locating your Taxpayer Identification Number (TIN), your business location, and your banking information. Step 3: Access SAM at https://www.sam.gov/portal/public/SAM/. Step 4: Create a SAM User Account if you do not already have one. Step 5: Register your Entity. During your registration, you may obtain your Unique Entity ID (UEI). Step 6: Remain in an 'active status' and update your information as needed.

For any questions regarding registration, please contact SAM Customer Service at Federal Service Desk (www.fsd.gov) Hours: 8am - 8pm (Eastern Time) US Calls: 866-606-8220 International Calls: 334-206-7828

How to Request Payment

When requesting payment, please submit a completed copy of the Medical Evidence of Record Billing Invoice that was included with the original medical evidence request. You also have the option of submitting your own invoice on your office letterhead. Please remember to

MEF-IP1-1 MEF/IP1 (07/15) DA 16 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023

include the claimant's name, the contract number, your Tax ID number (987654321), your current address.

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Benefit Assessment Services in your state; however, as a federal program we are exempt from paying state sales tax.

How to Get Payment Information

To obtain information on how to contact NBA regarding a vendor payment, please visit http://www.nationalbenefitsagency.gov/vendor/contact.htm. If you are enrolled in the Federal Payment Gateway (FPG), please visit www.fpg.gov to obtain vendor payment information. You can access FPG with your user ID and password to receive the status of your payments for the past 30 days. Information is available as of the payment date. FPG will provide the invoice number, payment amount, and payment date. In addition, you can request an email notification when payment data is available on the FPG website.

Thank you for your participation!

```
                                                    MET-IP1-1 MEF/IP1 (07/15
```

Back to top

WHOSE Records to be Disclosed		**Form Approved OMB No. 0960-0623**
NAME (First, Middle, Last, Suffix)	Birthday (mm/dd/yy)	
Arthur Miller	05/21/65	
SSN		
456-12-7890		

AUTHORIZATION TO DISCLOSE INFORMATION TO THE NATIONAL BENEFITS AGENCY (NBA)

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.

	THIS BOX TO BE COMPLETED BY NBA/ State Agency (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:
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 NBA - Employers, insurance companies, workers' compensation programs	Organization: Willow Creek Medical Center Vencor Address: 789 Oak Street, Springfield, IL 62704 Inpatient Date: 10/01/2023 TO CURRENT Outpatient Date: 10/01/2023 TO CURRENT

THIS BOX TO BE COMPLETED BY NBA/ State Agency (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

Patient DOB: 05/21/65
Remarks:

- Others who may know about my condition (family, neighbors, friends, public officials)

TO WHOM
The National Benefits Agency 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 NBA'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 NBA and my sources to revoke this authorization at any time (see page 2 for details).
- NBA 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 IF not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure	**Parent of minor [ ] Guardian [ ]**	**Other personal representative [ ] (explain)**	
SIGN ► Electronically signed by			
Arthur Miller			
Date Signed	Street Address		
08/15/22	789 Oak Ave		
Phone Number (with area code)	City	State	ZIP
773-555-9876	Chicago	IL	60601

WITNESS I know the person signing this form or am satisfied of this person's identity: Attested by NBA or Designated State Agency Employee:

SIGN ►	**Arthur Pendragon**	**IF needed, second witness sign here (e.g., if signed with "X" above)**
	Phone Number (or Address)	SIGN ►
	888-999-1234 Metropolis, MI 48201	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. Form SSA-827 (11-2012) ef (11-2012) Use 4-2009 and Later Editions Until Supply is Exhausted Page 1 of 2 01.19.2023 12:34:27 National Benefits Agency HelpDesk#:877-555-2000 Page 7/8

Explanation of Form SSA-827, "Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA 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), 233(d)(5)(A), 1614(a)(3)(H)(I), 1631(d)(1) and 1631(e)(1)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(II)(I), 1383(d)(1) and 1383(e)(1)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of National Benefits Agency programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to National Benefits Agency benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federallyfunded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089, Master Beneficiary Record, 60-0090, Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 0-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.nationalbenefitsagency.gov or at any National Benefits Agency office.

PAPERWORK REDUCTION ACT

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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at

www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form SSA-827 (11-2012) ef (11-2012) Page 2 of 2 19 of 19: 2F: Hospital Records - HOSPITAL Src: WILLOW CREEK MEDICAL CENTER 09/15/2022 - 01/18/2023

01.19.2023 12:35:44 National Benefits Agency HelpDesk#:8775552000 Page 8/8

NATIONAL BENEFITS AGENCY Texoma Records Processing Unit Floor 3, 99 Downtown Blvd Texoma, TX 75001-1234

STOLOS

MEDICAL EVIDENCE OF RECORD BILLING INVOICE

Contract Number: 448620 Service Vendor: E001580 WILLOW CREEK MEDICAL CENTER 789 OAK STREET SPRINGFIELD, IL 62704 Service Vendor Phone: (217) 555-7890 Service Vendor FAX: (217) 555-7891 PAY TO: E001581 WILLOW CREEK MEDICAL CENTER 789 OAK STREET SPRINGFIELD IL 62704 NOTE:

Date: January 19, 2023 Re: ARTHUR MILLER CHICAGO, IL 60601

SSN: XXX-XX-7890 DDS Case Number: 987654 AMOUNT AUTHORIZED: $15.00

TOTAL AMOUNT BILLED (Do NOT Include Sales Tax) $ ___

IF NO CHARGE, CHECK HERE [ ]

TAXPAYER ID NUMBER:_ DUNS:_ EIN if corporation or partnership SSN if payment should be made to an individual

---

Provider's signature_ **Date**_ This invoice is void if not signed and submitted within 90 days from date of issue.

NBA USE ONLY

Approved amount: $__ Number of Pages:__ Approved by:__ **Date:**

Auditor's Signature_ **Date**_

MER-NC3-1 NEF NC3 (05/15)

1 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023 2023-02-09 12:53 METROWELLNESS GRAND RAPIDS 16165557890 >> HelpDesk#:8775552000 P 8/13 MILLER, ARTHUR - C-987654321

Orthopedics Clinic Note Final Report

Result type: Orthopedics Clinic Note Result date: September 15, 2022 13:14 EDT Result status: Auth (Verified) Result title: Metro Wellness Office Visit Note Performed by: LEE LSW, DAVID on September 15, 2022 13:21 EDT Verified by: FINCH MD, ALISTAIR on September 22, 2022 10:05 EDT Encounter info: 680016671157, AMB DR ORTDHQ, Amb Outpatient-Active Chgs, 09/15/2022 - 09/25/2022

Final Report

Patient Demographics Patient Name: MILLER, ARTHUR Birth Date: 05/21/1965 Age: 57 years Gender: Male Date of Service: 09/15/2022 11:48 Referring Physician: VANCE MD, ELIAS

Problem List/Past Medical History Ongoing No qualifying data Historical No qualifying data

Procedure/Surgical History Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with o (11/29/2019), Administration of diphtheria-tetanus- pertussis, combined (07/10/2011).

Medications acetaminophen 500 mg oral tablet, disintegrating, 1 Tab, By Mouth, Q6, PRN

Allergies No Known Allergies

Social History Alcohol - Denies Alcohol Use Substance Abuse - Denies Substance Abuse Tobacco - Denies Tobacco Use Never smoker

Patient Demographics Patient Name: MILLER, ARTHUR Birth Date: 05/21/1965 Age: 57 years Gender: Male Date of Service: 09/15/2022 11:48

Orthopedics Clinic Note Final Report

Referring Physician: VANCE MD, ELIAS

Chief Complaint rthip

History of Present Illness Patient is a 58 year-old male who is presenting as a new patient with chronic R hip pain. Today, patient resting in a chair without distress. Patient has known arthritic changes noted in their R hip. Patient complaining of pain. Rates the pain as 8/10 and dull and achy in nature, with radiation to groin and buttock region. Pain is improved by rest. Pain is worsened by weight bearing activities such as standing, prolonged ambulation, and going up and down the stairs. Patient has attempted conservative treatment in the form of NSAIDS with mild relief. Has not attempted PT or Injections. Patient states he was in a MVC in 2012 and has had hip pain since then. However, the pain has worsened over the past two years. No recent acute events. Denies recent falls or injuries. Has been ambulating without assistive devices. Pain tolerated at baseline. Patient denies fever, chills, chest pain, shortness of breath, nausea, vomiting, weakness, tingling sensation, numbness, or any other joint pain. Interested in PT.

Physical Exam Vitals & Measurements HR: 94 (Monitored) BP: 126/86 WT: 69.85 kg BMI: 24.9 Pain Assessment: Pain Score (Activity) : 09/15/2022 13:00 8

Adult Pain Scale 13:00 VAS : 09/15/2022

General Appearance: Well-nourished, well developed in no acute distress Orientation: Oriented to person, place and time. Mood / Affect: Calm Gait: normal Coordination: normal

Hip Exam (Bilateral) Inspection / Palpation LE (R/L): TTP over Greater trochanter of R Hip R HIP: + FADIR, + FABER, +LOGROLL Hip Flexion (R/L): 120° / 120° Hip Extension (R/L): 20° / 20° Hip Adduction (R/L): 15° / 15° Hip Abduction (R/L): 40° / 40°

Orthopedics Clinic Note Final Report

Hip IR (R/L): 5°/5° Hip ER (R/L): 30°/30° Strength LE: 5/5 EHL, tibialis anterior, plantar flexion bilaterally Sensation: Subjective normal distal sensation bilaterally Vasculature: 2+ dorsalis pedis pulse bilaterally LE Skin: no rashes or lesions bilaterally Lymph LE: no inguinal lymphadenopathy DTR LE: Patellar (2+/2+); Achilles (2+/2+)

Diagnostic Studies XRAY HIP and PELVIS RIGHT DATE: 9/15/222 Severe subchondral sclerosis, and cystic changes in femoral head likely AVN.

Assessment/Plan

1. Avascular necrosis of bone of right hip 50 YO M with R Hip pain

Likely AVN based on radicgraphs Patient wants to try PT before considering further surgical options NSAIDs for pain relief Follow up as needed Ordered: Evaluation and Treatment (PT) - AMB

Orders: acetaminophen, = 1 Tab, By Mouth, Q6, PRN as needed for pain, # 50 Tab, 0 Refill(s) Diagnosis: M87.051 Idiopathic aseptic necrosis of right femur

I saw and evaluated the patient with the Resident, and I reviewed and discussed the case with the Resident and agree with the Resident's findings and plans as documented above. on9/15

Completed Action List: Perform by LEE, DAVID LSW on September 15, 2022 13:21 EDT Modify by LEE, DAVID LSW on September 15, 2022 14:02 EDT Sign by LEE, DAVID LSW on September 15, 2022 14:02 EDT Requested by LEE, DAVID LSW on September 15, 2022 13:21 EDT Modify by LEE, DAVID LSW on September 15, 2022 14:03 EDT Sign by LEE, DAVID LSW on September 15, 2022 14:03 EDT Modify by FINCH MD, ALISTAIR on September 22, 2022 10:05 EDT Sign by FINCH MD, ALISTAIR on September 22, 2022 10:05 EDT Requested by LEE, DAVID LSW MD-Resident, MUHAMMAD on September 15, 2022 14:03 EDT VERIFY by FINCH MD, ALISTAIR on September 22, 2022 10:05 EDT

Printed by: VANCE PHD, ELEANOR Printed on: 2/6/2023 09:40 EST Page 3 of 3 4 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023 2023-02-09 12:54 METROWELLNESS GRAND RAPIDS 16165557890 >> HelpDesk#:8775552000 P 11/13

MILLER, ARTHUR - C-987654321

Metro Health Clinic Note \ Final Report \

Result type: Metro Health Clinic Note Result date: January 26, 2023 12:03 EST Result status: Modified Result title: Metro Health Clinic Visit Note Performed by: SHARMA NP, ANYA S on January 26, 2023 12:21 EST Verified by: SHARMA NP, ANYA S on January 26, 2023 12:21 EST Encounter info: 680017147892, AMB DR ORTDHQ, Amb Outpatient-Active Chgs, 01/26/2023 - 02/05/2023

\ Final Report \ Document Contains Addenda

Patient Demographics Patient Name: MILLER, ARTHUR

Birth Date: 05/21/1965

Age: 57 years

Gender: Male

Date of Service: 01/26/2023 10:00

Referring Physician: FINCH MD, ALISTAIR

Chief Complaint Right Hip Osteoarthritis

History of Present Illness 57 year old male presents with complaints of continued right hip pain. He has had this hip pain since 2012 when he was involved in a motor vehicle accident. He states the pain has worsened over the past 2 years though. It is increased with activity, especially prolonged walking, stairs, and bending down to don shoes and socks. He was evaluated for this pain back in September and sent to Physical Therapy. He states therapy did not help, but actually made his pain worse. He has tried Physical Therapy and Antiinflammatories without symptomatic relief. He is here today interested in moving forward with surgical intervention.

Review of Systems Constitutional: Negative. Eye: Negative. Ear/Nose/Mouth/ Throat: Negative. Respiratory: Negative.

Printed by: VANCE PHD, ELEANOR Printed on: 2/6/2023 09:37 EST

Problem List/Past Medical History Ongoing Avascular necrosis of hip Historical No qualifying data

Procedure/Surgical History Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with o (11/29/2019),

Administration of diphtheria-tetanus- pertussis, combined (07/10/2011), Removal procedure (2005).

Medications No active medications

Allergies No Known Allergies

Social History Alcohol Current, Beer, Wine, 1-2 times per month Home/ Environment Lives with Alone. Living situation: Home/Independent. Family/ Friends available for support: Yes, Human Trafficking Red Flags None. Substance Abuse Current, Marijuana, Daily Tobacco Current some day smoker, Cigars

Diagnostic Results Old radiographs were reviewed. Sclerosis and joint space narrowing consistent with end stage arthritis are visualized. No obvious sign of deformity or fracture noted.

Back to top 5 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023 2023-02-09 12:54 METROWELLNESS GRAND RAPIDS 6165557890 >> HelpDesk#:8775552000 P 12/13

Orthopedics Clinic Note Final Report arthroplasty. He will need to obtain surgical clearance from his PCP prior to surgery. Patient is agreeable with plan. MILLER, ARTHUR - C-987654321

Addendum by Finch MD, Alistair on January 26, 2023 13:13:23 EST (Verified) I have seen and evaluated the patient and agree with the plan set forth by the PA. The examination is intact distally and I agree with the diagnosis. on 1/26.

Completed Action List: Perform by SHARMA NP, ANYA N on January 26, 2023 12:21 EST Sign by SHARMA NP, ANYA S on January 26, 2023 12:21 EST VERIFY by SHARMA NP, ANYA S on January 26, 2023 12:21 EST Modify by Finch MD, Alistair on January 26, 2023 13:13 EST Sign by Finch MD, Alistair on January 26, 2023 13:13 EST Requested by SHARMA NP, ANYA N. on January 26, 2023 12:21 EST

Printed by: VANCE PHD, ELEANOR Printed on: 2/6/2023 09:37 EST Page 3 of 3 Orthopedics Clinic Note \ Final Report \ MILLER, ARTHUR - C-987654321

Cardiovascular: Negative. Gastrointestinal: Negative. Genitourinary: Negative. Hematology/Lymphatics: Negative. Immunologic: Negative. Musculoskeletal: Negative except as documented in history of present Illness. Integumentary: Negative. Neurologic: Negative. Psychiatric: Negative. All other systems are negative

Physical Exam Vitals & Measurements HR: 100 (Monitored) BP: 150/8/ WT: 77.15 kg BMI: 27.5 Pain Assessment: Pain Score (Activity) : 01/26/2023 10:00 10

Adult Pain Scale : 01/26/2023 10:00 VAS

General: No acute Distress Alert and Oriented x3 Mood and Affect appropriate Gait antalgic Inspection: Right hip shows no obvious deformity Right Hip Palpation: No tenderness to palpation Right Hip ROM: Active: Flexion 90 Extension 0 Abduction 10 Adduction 0 IR 0 ER 15

Pain with active range of motion, + Log Roll

Right LE Neurovascularly intact, 2+ DP pulse, +EHL/FHI/GSC/TA, sensation intact to light touch along 1st dorsal webspace, lateral, and plantar aspects of the foot.

Assessment/Plan Osteoarthritis of right hip Diagnosis: M16.11 Unilateral primary osteoarthritis, right hip

The patient was seen and examined by myself and Dr. Alistair Finch. He has failed conservative treatment including pain medication, antiinflammatories and PT. The patient would benefit from surgical intervention at this point. We will have him meet with our surgical scheduler and pick a date for a right total hip

Printed by: VANCE PHD, ELEANOR Page 2 of 3 Printed on: 2/6/2023 09:37 FST 7 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023 2023-02-09 12:51 METROWELLNESS GRAND RAPIDS 1-616-555-7890 >> HelpDesk#:877-555-2000 P 3/13

NATIONAL BENEFITS AGENCY Texoma Records Processing Unit PO Box 5001 New Town, KY 40701-0002

January 11, 2023

CLINIC - CENTRAL METRO HEALTH & WELLNESS 5900 Division Ave S Ste 120 Grand Rapids MI 49548 Texoma Records Processing Unit PO Box 5001 New Town, KY 40701-0002

RQID:00987654000447443003 SSN: DOCTYPE: 0001 RF:D CS:daal

SSN: XXX-XX-7890 Claimant: ARTHUR MILLER

+--+ | This page must be on top of your records. | | Slide this page into the return window envelope | | with this address showing. | +--+

PLEASE NOTE: NBA has contracted with a specialized vendor to scan your medical records before they are sent to the DDS. Therefore, your response must be sent to the address as indicated above and in the box to the right. Do NOT send your records directly to the DDS.

IN ORDER TO RECEIVE PAYMENT FOR YOUR RECORDS, PLEASE SUBMIT AN INVOICE ON YOUR OFFICE LETTERHEAD WITH THE CLAIMANT'S NAME AND SSN AND YOUR DUNS. THE INVOICE MUST BE PLACED BEHIND THIS BAR CODED PAGE.

TO EXPEDITE YOUR RESPONSE FAX RECORDS TO: 1-877-555-4002

If you are sending records for more than one individual, you may place all of the records in the same envelope, or fax them at the same time. However, you must put the barcode page for each individual on TOP of THEIR own individual records.

To send us records electronically go to NBA's free, secure website address at: http://secure.nba.gov. Use the 3 character site code from the barcode as the destination for sending the records.

To register for access or for additional information, call the Secure Transmissions Help Desk Help Desk at 1-866-555-5000 or send them an email at secure-transmissions@nba.gov

MEF-IP2-1 MEF IP2 (10/11) 8 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023

2023-02-09 12:52 METROWELLNESS GRAND RAPIDS 16165557890 >> HelpDesk#:8775552000 P 4/13

NATIONAL BENEFITS AGENCY

Requesting Payment for Medical Records

The National Benefits Agency (NBA) pays for medical records or photocopies according to the fee schedule approved by the Benefits Processing Division of the state in which the claimant resides.

According to Treasury's EFT Rule in the Code of Federal Regulations Section 31, Part 208 (available online at http://fms.treas.gov/eft/index.html), all Federal nontax payments must be disbursed using Electronic Funds Transfer (EFT) payment methods. Therefore, vendors are required to register in the System for Award Management (SAM). Providing EFT information, such as banking information, ensures that payments reach vendors in a secure and timely manner. By enrolling in SAM, NBA will automatically receive any information updates a vendor makes in SAM. You are encouraged to register in SAM now in anticipation of the change to EFT payments. Registration in SAM is free of charge.

If you have not already registered in SAM to receive your payments electronically, please see the instructions below. Step 1: Prepare to register in SAM by locating your Taxpayer Identification Number (TIN), your business location, and your banking information. Step 3: Access SAM at https://www.sam.gov/portal/public/SAM/. Step 4: Create a SAM User Account if you do not already have one. Step 5: Register your Entity. During your registration, you may obtain your Unique Entity ID (UEI). Step 6: Remain in an 'active status' and update your information as needed.

For any questions regarding registration, please contact SAM Customer Service at Federal Service Desk (www.fsd.gov)

Hours: 8am - 8pm (Eastern Time) US Calls: 866-606-8220 International Calls: 334-206-7828

How to Request Payment

MEF-IP2-1 MEF IP2 (02/11)

Back to top 9 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023 2023-02-09 12:52 METROWELLNESS GRAND RAPIDS 16165557890 >> HelpDesk#:8775552000 P 5/13

When requesting payment, please submit a completed copy of the Medical Evidence of Record Billing Invoice that was included with the original medical evidence request. You also have the option of submitting your own invoice on your office letterhead. Please remember to include the claimant's name, the contract number, your Tax ID number, your current address, and your DUNS number.

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Benefits Eligibility Division in your state; however, as a federal program we are exempt from paying state sales tax.

How to Get Payment Information

To obtain information on how to contact NBA regarding a vendor payment, please visit http://www.nationalbenefitsagency.gov/vendor/contact. You are enrolled in the Department of Finance's Electronic Payment System (EPS), please visit www.eps.gov to obtain vendor payment information. You can access EPS with your user ID and password to receive the status of your payments for the past 30 days. Information is available as of the payment date. EPS will provide the invoice number, payment amount, and payment date. In addition, you can request an email notification when payment data is available on the EPS website.

Thank you for your participation!

MEF-112.1 NEF 1F2 (05/11)

Back to top 10 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023 2023-02-09 12:52 METROWELLNESS GRAND RAPIDS 16165557890 >> HelpDesk#:8775552000 P 6/13

WHOSE Records to be Disclosed Form Approved	
NAME (First, Middle, Last, Suffix)	OMB No. 0960-6623
Arthur Miller	
SSN	Birthday (mm/dd/yy)
456-12-7890	05/21/65

AUTHORIZATION TO DISCLOSE INFORMATION TO THE NATIONAL BENEFITS AGENCY (NBA)

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 NBA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY NBA/State agency authorized to process my case (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

Organization: METRO HEALTH & WELLNESS Vendor Address: 5900 DIVISION AVE S, STE 120, GRAND RAPIDS MI 49548 Inpatient Date: 07/01/2021 TO CURRENT Outpatient Date: 07/01/2021 TO CURRENT Patient DOE: 05/21/65 Remarks:

TO WHOM The National Benefits Agency 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 NBA'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 NBA and my sources to revoke this authorization at any time (see page 2 for details).
- NBA 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 IF not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure	**[ ] Parent of minor [ ] Guardian [ ] Other personal representative (explain)**		
SIGN ▶	Parent/guardian/personal representative sign		
Electronically signed by Arthur Miller	here if two signatures required by State law)		
Date Signed	Street Address		
08/15/22	789 OAK AVE		
Phone Number (with area code)	City	State	ZIP
773-555-9876	CHICAGO	IL	60601

WITNESS I know the person signing this form or am satisfied of this person's identity:	**IF needed, second witness sign here (e.g., if signed with "X" above)**
Attested by NBA or Designated State/Agency Employee:	SIGN ▶
SIGN ▶ Alex Smith	Phone Number (or Address)
Phone Number (or Address)	
888-999-1234 METROPOLIS MI 48201	

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. Form NBA-827 (11-2012) of (11-2012) Use 4-2009 and Later Editions Until Supply is Exhausted Page1 of 2

Back to top 11 of 11: 3F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #2 09/15/2022 - 01/26/2023 2023-02-09 12:53 METROWELLNESS GRAND RAPIDS 16165557890 >> HelpDesk#:8775552000 P 7/13

Explanation of Form NBA-827, "Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 NBA-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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you. NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA makes every reasonable effort to ensure that the information in the NBA-827 is provided to you in your native or preferred language.

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(t)(1) and 1631(e)(1)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(cd)(1) and 1383(e)(1)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of National Benefits Agency programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to National Benefits Agency benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federallyfunded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Case File System, 70-0011; Main Client Database, 70-0022; Community Support Records and Special Assistance Benefits, 70-0033; and Digital Appeals (eDAP) Case File, 0-0450. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www. nationalbenefitsagency.gov or at any National Benefits Agency office.

PAPERWORK REDUCTION ACT

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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Health Information Technology (HIT) Medical Report

SSA Disclaimer: The following displays data transmitted to the NBA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. sample).

Summary of episode note Continuity of Care Document

Received From: Unity Care Clinic

Creation Date:	Date Range Requested:	Type of Request:
03/15/2023	08/01/2021 - 03/15/2023	User Triggered

Arthur Miller DOB: 05/21/1965 Gender: Male SSN: 456-12-7890

Partner Medical Record Demographics: Name: Arthur Miller (Legal) DOB: 05/21/1965 Gender: Male

Back to top 2 of 3: 4F: HIT MER - HITMER Src: Unity Care Clinic 02/09/2023

Table of Contents

Section Name Page Healthcare Providers [PROV LIST].....3 Medication Information [MEDS].....3 Plan of Care [CARE PLAN].....3

Back to top 3 of 3: 4F: HIT MER - HITMER Src: Unity Care Clinic 02/09/2023

PROV LIST

Healthcare Providers

Unity Care Clinic (06/14/2016 - No Date Available)

Provider Name	Address	Telecom	MRN
Elena Petrova, MD		tel:+1-415-555-0187, fax:+1-415-555-0189 +1-415-555-0188	98765432

MEDS

Medication Information

Narrative Text No known medications

CARE PLAN

Plan of Care

Narrative Text Not on file

Back to top

1 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient: MILLER, ARTHUR Printed by: BENNETT, CLARA

MRN: J-987654321 Printed on: 03/07/2023 14:17 EST

CENTRAL PLAINS MEDICAL CENTER

CIS on-line facesheet

Patient: MILLER, ARTHUR Date of Birth: 05/21/65 00: FIN : 987654321098 Age: 57 Years Gender: Male MRN: xxxxx4321 Race: Not Specified Marital Sts: Married SSN : XXX-XX-XXXX Preferred Language: English Religion: Not Specified Adv Dir: No PTID: 98765432 Location: AMSHHQ - Pat Sts: Outpatient-Active Pat Type: Outpatient Procedure Adm Src: Outpatient Clinic Adm type: Routine Elective Admit dt: 04/10/2023 04:00 Med Srvc: Medical Services (Internal Medicine) Adm Diag: ADMITTING DIAGNOSIS Disch dt: 04/12/2023 15:38 Accident Desc: Condition Related Accident Dt: Discharge Disp: Alive Pt Hm Addr: 789 OAK AVE City,St Zip: CHICAGO, IL 60601 Pt Hm Ph: 7735559876 Pt Wk Addr: City,St Zip: Pt Wk Ph: Attending Phy: FINCH MD, ALISTAIR NPI: 9876543210 Atn*Doc*Nbr: 543210 Admitting Doc: FINCH MD, ALISTAIR Prim Care Doc: VANCE MD, ELIAS NPI: 1234567890 Publicity_ind: No Restrictions Referring Doc: FINCH MD, ALISTAIR Financial Class: Managed Care Plan Dr on Ins Card :

Expected Arrival Date: 04/10/23

----------Emergency Contact Information---------- Relationship to Patient: Associate Hm Address: Hm Ph: 7735550100 Name: JOHNSON, SARAH City St Zip: Wk Ph:

----------Guarantor Information---------- Relationship to Patient: Associate Hm Address: 789 OAK AVE Hm Ph: 7735559876 Name: MILLER, ARTHUR City St Zip: CHICAGO, IL 60601 Guar SSN: XXX-XX-XXXX Contact for Surgical Consent:

----------Insurance Information---------- COB#: 1 Plan Code: P99 Plan Desc: GENTLE HANDS PLAN Eff Date: 03/01/23 Exp Date: 12/31/2100 Refer : Bnft Days Avail: Auth/Pace#: UNKNOWN Verified: NO Policy/HIC/R#: 0123456789 SVCD : GRP: CoPay%: 0 CoPay$: 0 Deduct: 0.00 Authorization Name: Auth Ph : PreCert: No ReCert: NO Call Back Name: Call Back Ph ; Days: 0

Mail to: Attn: Subscriber: MILLER, ARTHUR SSN: XXX-XX-XXXX Street: P.O. Box 789 Benefits Per: Sex: Male

CityStZip: Harmony Creek, CA 90211 Phone #: Relation: SELF DOB: 05/21/65 00:00:00

Pre Registered by: THOMPSON, OLIVIA Date: 03/01/23 09:30 123456 Full Registered by: Contributor_system, Date: 04/10/23 04:00

Prairie General Hospital

Page 1 2 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Central Plains

Central Plains Medical Center

Patient Name: MILLER, ARTHUR	**Facility: Willow Creek Medical Center**
DOB: 05/21/1965	Address: 789 Oak Street
PTID: 40257359	Springfield, IL 62704
FIN: DE9876543210	
PCP: VANCE MD,ELIAS	Admit Date: 2/8/2023
Attending: FINCH MD,ALISTAIR	Discharge Date: 2/9/2023
	Medical Service: Surgery (General)

Name History

Patient names	Begin Date Time	End Effective Dt	Name Type
MILLER, ARTHUR	01/03/2008 00:11		Current

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity name above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Community Health Clinic of Oakwood - 734-987-6543 City General Hospital - 555-123-4567 Prairie General Hospital - 402-555-1234 Summit Peak Medical Center - +1-720-555-0189 Oakwood Springs Medical Center - 734-555-0123 Evergreen Physical Therapy & Wellness - 503-555-0199 Community Health Clinic - 555-123-4567

3 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023
FIN: DE9876543210

Problem List

Problem Name: At risk for falls Recorder: SYSTEM,SYSTEM Last Updated: 2/9/2023 07:49 EST; SYSTEM,SYSTEM Onset Date: 2/9/2023; Status Date: 2/9/2023; Prognosis:

Problem Name: Avascular necrosis of hip Recorder: JENKINS RN,SARAH Last Updated: 1/18/2023 08:00 EST; JENKINS RN,SARAH Onset Date: ; Status Date: 1/18/2023; Prognosis:

Back to top 4 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Cardiology Documents

Back to top SVC01 Auth (Verified) DE9876543210 13:06 8FEB2023 MANUAL RECORDING Page 1 SPEED-25.00 MM/S Pudy 37 [1] II MON HR =100 VE/MIN=0 2 [2] RA-LL RESP=21 3 [3] SPO2=97% 0 [4] NIBP=13:03 135/82(96) mmHg 5 • 5 0 2 3 0 5 4.0 MV [1] 0 P 0 0 40 0 30 [2] 0 20 8 10 6 0 2 -10

4.0 V [3] •

[4]

40 30 20 10 0 -10

FIN: DE9876543210 PTID: 98765432 MILLER, ARTHUR 05/21/1965 M MRN: XXXXX9876 AMSHHQ// DOS: PCP: VANCE, ELIAS DR. ATTN: FINCH, ALISTAIR DR. Auth (Verified) MILLER, ARTHUR MANUAL RECORDING DE9876543210 2 OPS22 Page 1 3 16:11 8FEB2023 0 SPEED-25.00 MM/S 1 II MON HR =66 VE/MIN=0 ALARM AFIB 5 2 RA-LL RESP=18 5 3 SPO2-100% 0 4.0 MV 4 NIBP-16:00 114/72(82) mmllg 3 0 5 P 40 [1] 0 30 0 20 0 10 0 0 0 -10 0 8 6 4.0 MV [1] 2 18 [2] 31 40 30 [3] 20 10 0 -10 [4]

FIN: DE9876543210 PTID: 98765432 MILLER, ARTHUR 05/21/1965 M MRN: XXXXX1234 AMSHHQ// DOS: PCP: VANCE MD, ELIAS ATTN: FINCH MD, ALISTAIR 7 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 04/10/2024 - 04/24/2024

Patient Name: MILLER, ARTHUR Admit Date: 4/18/2024 FIN: DE9876543210

Consults

DOCUMENT NAME: Consultation SERVICE DATE/TIME: 4/18/2024 17:24 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: Dr. Elara Vance (4/18/2024 17:33 EST) SIGN INFORMATION: Dr. Elara Vance (4/18/2024 17:33 EST) AUTHENTICATED BY: Dr. Elara Vance (4/18/2024 17:33 EST)

Central Plains Medical Center Consultation "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Patient: MILLER, ARTHUR MRN: M-987654321 FIN: DE9876543210 Age: 58 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: None Author: Dr. Elara Vance

Document Created Document Creation: 04/18/24 17:24 .

Date of Service Date of Service: 04/18/2024. Consulting Service: Internal medicine.

Chief Complaint The patient is a 58 years old Male weighing 72.0 kg 158 lb. .

Referring physician Dr. Alistair Finch, Patient is seen and examined by medicine consultation for medical management and follow-up as per request of the primary team.

History of Present Illness

I performed a thorough and comprehensive history taking from the patient about current circumstances, pain distribution and severity of the pain alleviating and aggravating factors, Medication she is taking, past medical history, The patient is a pleasant 58-year-old male who has had chronic right hip pain secondary to o/a. The patient has failed all conservative measures and therefore has elected to proceed with the above-mentioned procedure. The risks, benefits and alternatives of treatment were discussed with the patient. Some of these risks included, but were not limited to infection, hematoma, DVT, PE, stroke, MI, fracture, dislocation, leg length discrepancy, neurovascular injury and even death. The patient expressed understanding of these risks and elected to proceed with robotic assisted total right hip arthroplasty. Patient activity of daily living being limited by the pain, patient takes analgesic treatment frequently, Patient was qualified for the procedure to reduce his symptoms of the pain and to improve his quality of life, he will be admitted to the floor to monitor his vital signs, pain control, he will be assisted by PT OT with the orthopedic team supervision, Will monitor vital signs, blood work-up, fluid balance, abnormal metabolic disorder to be corrected as needed, Patient is encouraged for more ambulation and to use incentive spirometer, Will continue on GI and DVT prophylaxis.

Consults

Post-Operative diagnosis Osteoarthritis of right hip (ICD10-CM M16.11, Admitting, Medical). Procedure performed Right Total Hip Arthroplasty.

Histories

Past Medical History:

```
Active
    Avascular necrosis of hip (5554321098)
    Comments:
        03/10/2024 EST 08:00 EST - JENKINS RN, SARAH
    Right
```

Family History:

```
No family history items have been selected or recorded.
```

Procedure History:

```
Emergency department visit for the evaluation and management of a patient,
components: A detailed history; A detailed examination; and Medical decisi
Counseling and/or coordination of care with o (99284) on 09/20/2021 at 47
Administration of diphtheria-tetanus-pertussis, combined (99.39) on 06/05/
Removal procedure (777888999) in 2010 at 34 Years.
Comments:
    03/10/2024 08:21 EST - JENKINS RN, SARAH
    "Knot on penis"
```

Social History

Social & Psychosocial Habits

```
Alcohol
    03/10/2024 Use: Current
```

Type: Beer, Wine
Frequency: 1-2 times per month
Comment: Instructed not to drink alcohol 24 hours prior to surgery - 0
Home/Environment
03/10/2024 Lives with: Alone
Living situation: Home/Independent
Family/Friends available to help: Yes
Human Trafficking Red Flags: None
Substance Abuse
03/10/2024 Use: Current
Type: Marijuana
Frequency: Daily
Comment: Instructed not to smoke 24 hours prior to surgery - 03/10/202
Tobacco
03/10/2024 Use: Current some day smoker
Type: Cigars
Comment: Instructed not to smoke 24 hours prior to surgery - 03/10/202

Family history is positive hypertension, overweight, dyslipidemia and osteoarthritis.

Consults

Review of Systems Musculoskeletal: Joint pain. All other systems are negative

Physical Examination VS/Measurements

Most recent Vital Signs last 24 hours:

Temperature:	36.0	using method Temporal
BP:	141/81	
Pulse:	59	
Respiration Rate:	13	
SpO2:	100	

FIO2:	-----	
24Hr Tmax:	37	using method Temporal

Weight:

Initial Weight:	72.9 kg 160 lb 02/02
Current Weight:	72.0 kg 158 lb 02/08

General: Alert and oriented, Well nourished, Well developed, No acute distress. Eye: Pupils are equal, round and reactive to light, Intact accommodation, Normal conjunctiva, visual disturbance since last 4-5 months. HENT: Normocephalic, Atraumatic, Normal hearing, Oral mucosa is moist. Respiratory: Lungs CTA bilaterally, No wheeze, Respirations are non-labored. Cardiovascular: Regular rate, Regular rhythm, S1 auscultated, S2 auscultated, No edema. Gastrointestinal: Soft, Non-distended, BLE mild tenderness. Musculoskeletal: Patient has a dressing on the I site of surgery, no obvious bleeding or drainage, decrease range of motion, Integumentary: Warm, Dry, Intact. Neurologic: Alert, Oriented, Normal sensory, Normal motor function, No focal defects. Psychiatric: Cooperative, crying on and off while having conversation with the patient

Impression and Plan

Post-Operative diagnosis Osteoarthritis of right hip (ICD10-CM M16.11, Admitting, Medical). Procedure performed Right Total Hip Arthroplasty.

Patient Name: MILLER, ARTHUR FIN: DE9876543210 Admit Date: 2/8/2024

Consults

I performed a comprehensive physical exam on the patient including all systems, A comprehensive medical decision making,

I reviewed patient medical record, EKG, chest x-ray, blood work-up, Cardiac clearance,

-Acute right hip pain secondary to right total hip arthroplasty, post op care and pain control per Ortho team, Continue local care, follow with the instruction of

physical occupational therapist with supervision of orthopedic team. Resume medication prescribed by orthopedic team.

-Few readings of elevated blood pressure without history of hypertension, Will continue to monitor vital signs, electrolytes, fluid balance, pain and nausea symptoms,

-Bradycardia, Is mild patient has few readings of low heart rate, Is probably reactive to a vagal reflex from anesthesia and surgery, will continue to follow vital signs, electrolytes, no additional treatment is needed, patient is asymptomatic.

-History of dyslipidemia, No records available, patient can check lipid profile and liver function test with primary care doctor to discuss about risk factor diet modification of lifestyle diet and activity.

-GERD, Described as occasional and mild by the patient, discussed about the PPI treatment, modification of diet and timing of the meal.

-Tobacco dependence/marijuana use, Discussed with patient about potential risk and complication and availability of medical treatment and counseling, nicotine patch, Will keep oxygenation within normal range, encouraged use of incentive spirometer,

-Vitamin D deficiency, Continue p.o. supplement, follow with the serum level as outpatient.

-Debility, Secondary to above and the recent right total hip arthroplasty, patient will be assisted by PT OT and orthopedic team for activity of daily living.

-Encouraged ambulation and the use of incentive spirometer.

-GI and DVT prophylaxis.

Thanks for the consultation we will follow with you.

Consults

Created by VANCE, ELARA Dr. Phone number 555-0101. Service Internal medicine. Attending.

Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT,CLARA Page 10 of 84

Back to top 12 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023

FIN: 987654321098

Diagnostics

Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 11 of 84

Back to top 13 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

\ Auth (Verified) \ DE9876543210

Patient: MILLER, ARTHUR MRN: C-987654321 Date Range: 02/01/2023 12:50 EST - 02/09/2023 12:50 EST

Laboratory	**02/02/2023 11:06 EST**	**02/02/2023 09:56 EST**	**02/02/2023 09:55 EST**
Chemistry			
Sodium			140
Potassium			3.9
Chloride			105
Carbon Dioxide			27
Anion Gap			8
Glucose			\85
Urea Nitrogen (BUN)			17
Creatinine			0.96
Calcium			9.8

Laboratory	02/02/2023 11:06 EST	02/02/2023 09:56 EST	02/02/2023 09:55 EST
GFR for African Amer			\ 100
GFR for Other Races			83
Hematology/Hemostasis			
WBC			8.0
RBC			5.02
Hemoglobin			14.1
Hematocrit			42.9
MCV			85.5
MCH			28.1
MCHC			32.9
Red Cell Distribution Width (RDW)			13.3
Platelets			227
Mean Platelet Volume (MPV)			10.9
Nucleated RBC s			0.00
Urinalysis			
Urine Appearance			CLEAR
Urine Color			YELLOW
Urine Glucose			NEGATIVE
Urine Bilirubin			NEGATIVE
Urine Ketones			NEGATIVE
Urine Specific Gravity			1.025
Urine Blood			NEGATIVE
Urine pH			5.5
Urine Protein			TRACE
Urine Urobilinogen			NEGATIVE
Urine Nitrite			NEGATIVE
Urine Leukocyte Esterase			NEGATIVE
Urine RBC's			CRITERIA NOT M
Blood Bank			
Type And Screen			(c) Type And Sci

Flowsheet Print Request

Printed by: PETROVA RN, ANASTASIA Printed on: 02/08/2023 12:50 EST

FIN: DE9876543210 PTID: 40257359 MILLER, ARTHUR 05/21/1965 M MRN: C-987654321 CP - 1AWS / 1234 / 02 DOS: 02/08/23 04:00 PCP: VANCE MD, ELIAS ATTN: FINCH, ALISTAIR MD

Page 1 14 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: DE9876543210

Discharge Summary

DOCUMENT NAME: MLP Discharge Summary SERVICE DATE/TIME: 2/9/2023 13:42 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: VANCE CNP,ELEANOR (2/9/2023 13:46 EST) SIGN INFORMATION: VANCE CNP,ELEANOR (2/9/2023 13:46 EST) AUTHENTICATED BY: VANCE CNP,ELEANOR (2/9/2023 13:46 EST)

DMC MLP Discharge Summary "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Patient: MILLER, ARTHUR MRN: H-987654321 FIN: DE9876543210 Age: 57 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: Osteoarthritis of right hip; s/p Right total hip arthroplasty Author: Eleanor Vance, NP

Date of Service Date of Service: 02/09/2023.

Discharge Information Discharge Summary Information: Admitted 02/08/2023, Discharged 02/09/2023. Attending physician: FINCH MD, ALISTAIR. Admitting diagnosis: Osteoarthritis of right hip (ICD10-CM M16.11, Admitting, Medical). Discharge diagnosis: S/p Right total hip arthroplasty (ICD10-CM Z96.641, Discharge, Medical). Allergies: Allergic Reactions (Selected) No Known Allergies.

Hospital Course Mr. Arthur Miller is a 57 year old male with a history of right hip osteoarthritis. After failed conservative treatment it was decided it would be beneficial to undergo a total hip replacement. Patient was admitted to the hospital and preceded with surgery on 2/8/2023. Post operatively patient was admitted to the medical/surgical orthopedic unit for monitoring and pain management.

Medicine service was consulted for any medical issues should they arise. Medical management by Dr. Elara Vance.

Post operatively Foley catheter was discontinued on POD # 1 patient was able to void afterwards. Stool softeners were ordered to avoid post op constipation, +flatus when discharged. Pain medication was transitioned from IV to oral. Patient worked with physical and occupational therapy daily and progressed toward goals. When pain was controlled and therapy cleared the patient to ambulate safely with a walker, patient was discharged home with family and home health care, RN and PT/OT. Aspirin 81 mg twice daily for DVT prophylaxis will continue for one month. Prescriptions were written for durable medical equipment as recommended by PT/OT and pain medication for use at home, Norco 10/325 mg. Patient will follow up with Dr. Alistair Finch in two weeks.

Pain medication history was reviewed in MAPS prior to discharge.

Discharge Physical Examination VS/Measurements

Report Request ID: 987654321 Printed On: 4/15/2023 10:00 EST Requester: BENNETT, CLARA Page XX of YY 15 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Discharge Summary

Most recent Vital Signs last 24 hours:

Temperature: 37.2 using method Oral BP: 139/73 Pulse: 92 Respiration Rate: 16 SpO2: 98 FIO2: --- 24Hr Tmax: 37.2 using method Oral

Weight:

Initial Weight: 72.9 kg 160 lb 02/02 Current Weight: 72.0 kg 158 lb 02/08

. Measurements from flowsheet : Measurements 02/08/2023 12:52 EST Height Mode Stated Height 170 cm Height/Length Height Weight Mode Stated Weight 72 kg BSA 1.8315 BSA Mosteller 1.8439

General: Alert and oriented, No acute distress. Respiratory: Respirations are non-labored. Cardiovascular: Good pulses equal in all extremities. Musculoskeletal: Cooperative with therapy, progressing ok. RLE hip incision with steri strips intact.

Post op dressing removed, dry dressing applied. Minimal drainage. Sensation wnl, +dorsi/pedal flexion, +pulse.

Integumentary: Warm, Dry. Neurologic: Alert, Oriented. Psychiatric: Cooperative, Appropriate mood & affect.

Quality and Safety Quality and Safety: At risk for falls: 02/09/2023 07:00 EST .

Discharge Plan Discharge Summary Plan Discharge Condition: stable. Discharge instructions given: to patient, verbal discharge instructions (activity level, follow-up appointment, medications, symptoms worsening), written discharge instructions (activity level, follow-up appointment, medications, symptoms worsening). Discharge disposition: discharge to home (into the care of family member, with home health care). Activity: Weight bear as tolerated right lower extremity, ambulate with walker until cleared by therapy. Discharge Medications: MEDICATIONS:

Patient Name: MILLER, ARTHUR FIN: DE9876543210 Admit Date: 2/8/2023

Discharge Summary

aspirin (aspirin 81 mg oral delayed release tablet) 1 Tab By Mouth Two times daily DVT prevention docusate (Colace 100 mg oral capsule) 1 Cap By Mouth Two times daily prevent constipation Take with plenty of water, hold for loose s acetaminophen-HYDROcodone (Norco 10 mg-325 mg oral tablet) 1 Tab By Mouth Every 4 hours as needed for pain not to exceed 6 tablets/da

Diagnosis Status

Improving.

Education and Follow-up

Counseled patient, regarding treatment, regarding medications. Discharge Planning: Discharge instructions Dr. Alistair Finch THA (Custom) csmith (CSMITH), Hip Precautions, Follow up with primary care provider Within 1 to 2 weeks; Alistair Finch 2/21/2023 10:00:00.

Professional Services

Creator Information: ELEANOR VANCE, NP, Ext. 4321, Nurse Practitioner. Participation I spent 30 minutes with the patient. Service orthopedic surgery, Central Plains Medical Center. MLP Role: Acting in collaboration with Central Plains Medical Center Employed Physician.

Back to top 17 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admission Date: 2/8/2023 FIN: 987654321098

Ed Documents

DOCUMENT NAME: Patient Acknowledgement SERVICE DATE/TIME: 2/8/2023 12:31 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: SIGN INFORMATION: AUTHENTICATED BY:

Back to top 18 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023

FIN: 987654321098

Ed Documents

Attachment(s): 2/8/2023 12:31 EST iDocPFS14101645.tiff

CENTRAL PLAINS MEDICAL CENTER FIN: 987654321098 PTID:40257359 Electronically Signed - Witness: CENTRAL PLAINS MEDICAL CENTER MILLER, ARTHUR AliceJohnsonSig OCHM K 05/21/1965 M MRN:(MEDICALRECORDNUMBE [Johnson, Alice] 2/8/2023 12:30 PM DRM RM AMSHHQ DOS:02/08/2023 04:00 NUM OSGN PCP:DR. VANCE. ELIAS HYSH HEART ATTN:DR. FINCH. ALISTAIR NWN 1002

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, parent, or the patient's personal representative.

Arthur Miller __ _ __ Signature of Patient / Parent / Personal Representative Date Relationship to Patient

MILLER, ARTHUR

Print Name

FOR INTERNAL USE ONLY

__ _ _ Name of Employee (Print) Signature of Employee Date Johnson, Alice AliceJohnsonSig 2/8/2023

If applicable, reason patient's written acknowledgment could not be obtained:

- [ ] Patient was unable to sign.
- [ ] Patient refused to sign.
- [ ] Other: __

Version 1 (Version: as noted on NPP) 03/01/21 (Date: as noted on NPP)

3225608Y (05/21)

iDocPFS14101645.tiff Please click on link to see image.

Back to top 19 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Back to top DE9876543210 2 3 CPMC FIN: DE9876543210 PTID: 98765432 0 CENTRAL PLAINS MEDICAL CENTER MILLER, ARTHUR MRN: XXXXX1234 5 05/21/1965 M DOS: 02/08/23 04:00 5 HA - 2BNS / 2613 / 01 0 PCP: VANCE MD, ELIAS 3 ATTN: GREEN MD, DAVID S 0 5 0 0 0 0 0 8 6 0

Patient FALL RISK SELF - ASSESSMENT

(To be filled out at time of admission)

Please circle YES or NO for each statement below:	**Why is this Important**
Yes = 2 (No = 0) I have fallen in the past year.	People who have fallen once are likely to fall again.
(Yes = 2) No = 0 I use or have been told to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes = 2 (No = 0) Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
(Yes = 2) No = 0 I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
(Yes = 2) No = 0 I am worried about falling.	People who are worried about falling are more likely to fall.
(Yes = 2) No = 0 I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
(Yes = 2) No = 0 I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes = 2 (No = 0) I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes = 2 (No = 0) I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.

Please circle YES or NO for each statement below:	Why is this Important
Yes = 2 (No = 0) I take medication that sometimes makes me feel light-headed or more tired than usual.	Side effects from medications can sometimes increase your chance of falling.
Yes = 2 (No = 0) I take medicine to help me sleep or improve my mood.	These medications can sometimes increase your chance of falling.
Yes = 2 (No = 0) I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.

Total Score: 6 Add up the number of points for each "YES" answer. Score If you score 4 points or more, you ARE at risk for falling.

Patient / Family Signature: _Xanthur Miller_____ Date: _____03/15/24_____ Time: __0845__

Preventing avoidable falls. Universal environmental precautions.

87654321 (03/24) Original: Chart Yellow: Patient 21 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Transcribed DE9876543210

To Our Patients and Families

Hospitalized patients are at risk for a fall. We do not want you to fall or hurt yourself in any way.

The tips for fall prevention that we discussed are listed below. Please share this information with your family.

If you scored a 4 or more on your risk assessment, you are already at risk for a fall prior to being admitted to the hospital. You are at a greater risk for falling while in the hospital.

Always call when you need to get out of bed. Staff will assist you so that you do NOT fall. Our motto is "CALL... DON'T FALL!"

Falling can result in serious injuries such as hip fractures or a head injury with bleeding that can lead to permanent disability. If you had surgery, you may injure or damage the surgical incision during a fall.

We will be making hourly rounds to see what your needs are and to help you.

It is very important that you work with your caregiver's to help you avoid falling.

We may need to stay with you in the bathroom. We know your privacy is important, but your safety is more important.

If your family is assisting you, please be sure that you call us when they leave.

987654321Q000000123

We care about you and your safety! As the most important member of the health care team, we need you to partner with us for your safety.

Preventing avoidable falls. Universal environmental precautions.

CPMC Central Plains Medical Center

87654321 (06/17)

22 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center / Prairie General Hospital 01/27/2023 - 02/09/2023

Back to top 23 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: DE9876543210

History and Physical

DOCUMENT NAME: History and Physical SERVICE DATE/TIME: 2/8/2023 06:04 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: VANCE, ELEANOR LCSW (2/7/2023 22:05 EST) SIGN INFORMATION: Alistair Finch MD (3/7/2023 08:32 EST); VANCE, ELEANOR LCSW (2/7/2023 22:05 EST) Alistair Finch MD (3/7/2023 08:32 EST)

AUTHENTICATED BY: Alistair Finch MD (3/7/2023 08:32 EST)

Central Plains Medical Center History & Physical Update Note "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Patient: MILLER, ARTHUR MRN: C-987654321 FIN: DE9876543210 Age: 58 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: None Author: VANCE, ELEANOR LCSW

Basic Information Original History and Physical was performed by ANYA S SHARMA NP: On 01/26/2023. History was reviewed and the patient examined: Changes from the previous History & Physicial are: H&P updated. No changes in PMH/PSH/SOC/ALL/MEDS/FMHX since seen in clinic. The operation was discussed in great detail with all questions being answered to the patients satisfaction. The operative and non operative treatment options were discussed and the risks/ benefits to both as well. OK to proceed with operation. Verbal and written informed consent obtained.

Report Request ID: 987654321 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 22 of 84

Back to top 24 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 2/8/2023

Lab - Results

Lab - Point of Care

Procedure	Units	Reference Range	1/18/2023 07:58 EST	2/8/2023 12:52 EST	2/8/2023 18:51 EST
Pregnancy Status		N/A male	N/A male	N/A male	N/A male

Lab - Chemistry

Procedure	Units	Reference Range	2/2/2023 09:55 EST	2/9/2023 04:16 EST
Sodium	mMol/L	[136-145]	140[01]	136 [02]
Potassium	mMol/L	[3.5-5.1]	3.9 [01]	4.5 [02]
Chloride	mMol/L	[98-107]	105[01]	105 [02]
Carbon Dioxide	mMol/L	[21-31]	27 [01]	22 [02]
Anion Gap	mMol/L	[5-15]	8 [01]	9 [02]

Procedure	Units	Reference Range	2/2/2023 09:55 EST	2/9/2023 04:16 EST
Glucose	mg/dL	[75-105]	85 [01]	170[H] [02]
Urea Nitrogen (BUN)	mg/dL	[7-25]	17 [01]	19 [02]
Creatinine	mg/dL	[0.70-1.30]	0.96 [01]	0.87 [02]
Calcium	mg/dL	[8.6-10.8]	9.8 [01]	8.4[L] [02]
Magnesium	mg/dL	[1.6-3.0]	-	1.7 [03]
GFR for African Amer	mL/min/1.73 m2	[60-120]	100[01]	112 [02]
GFR for Other Races	mL/min/1.73 m2	[60-120]	83 [01]	92 [02]

Order Comments O1: Basic Metabolic Panel. Tube type and volume: Green Gel (preferred) Acceptable: Green, SST, Gold or Red, 0.5 mL O2: Basic Metabolic Panel. Tube type and volume: Green, SST, Gold or Red, 0.5 mL. Tube type and volume: Green Gel (preferred) Acceptable: Green, SST, Gold or Red, 0.5 mL O3: Magnesium-Laboratory Collect 1 Green Gel tube (preferred) Acceptable: SST, gold, green or red top tube.

Lab - Hematology/Hemostasis

Procedure	Units	Reference Range	2/2/2023 09:55 EST	2/9/2023 04:16 EST
WBC	K/CUMM	[3.5-10.6]	8.0 [04]	13.2[H] [05]
RBC	M/CUMM	[4.27-5.69]	5.02 [04]	4.12[L] [05]
Hemoglobin	gm/dL	[13.3-17.1]	14.1 [04]	11.4[L] [05]
Hematocrit	%	[38.9-49.7]	42.9 [04]	34.1[L] [05]
MCV	FL	[81-98]	85.5 [04]	82.8 [05]

Admit Date: 2/8/2023

Procedure	Units	Reference Range	Collected Date Collected Time 2/2/2023 09:55 EST	2/9/2023 04:16 EST
MCH	pg	[27.1-34.0]	28.1 O4	27.7 O5
MCHC	%	[32.6-35.4]	32.9 O4	33.4 O5
Red Cell Distribution Width (RDW)	%	[11.7-14.9]	13.3 O4	13.3 O5
Platelets	K/ CUMM	[150-450]	227 O4	210 O5
Mean Platelet Volume (MPV)	FL	[7.3-11.4]	10.9 O4	10.5 O5
Manual Diff Review			-	1 O5
Absolute Lymphocyte Count	K/ CUMM	[1.0-3.8]	-	1.7 O5
Lymphocyte %	%		-	13 O5
Absolute Monocyte Count	K/ CUMM	[0.1-0.88]	-	0.9 H O5
Monocyte %	%		-	7 O5
Absolute Neutrophil Count	K/ CUMM	[1.58-7.13]	-	10.5 H O5
Neutrophil %	%		-	80 O5
Absolute Eosinophil Count	K/ CUMM	[0.0-0.6]	-	0.0 O5
Eosinophil %	%		-	0 O5
Absolute Basophil Count	K/ CUMM	[0.0-0.20]	-	0.0 O5
Basophil %	%		-	0 O5
Nucleated RBCs	K/ CUMM		0.00 O4	0.00 O5
RBC Morphology			-	SLIGHT ANISOCYTOSIS O5
		[0.00-0.20]	-	0.1 O5

Procedure	Units	Reference Range	Collected Date Collected Time 2/2/2023 09:55 EST	2/9/2023 04:16 EST
Immature Granulocyte Absolute	K/ CUMM			
Immature Granulocyte %	%	[0-2]	-	0[O5]

Order Comments O4: Complete Blood Count Collect One lavender top tube. O5: Complete Blood Count with Differential Collect One lavender top tube. Order not more than one within a 24 hour period, per protocol. Note: Abnormal findings reflex to manual differential. Collect One lavender top tube. Note: Abnormal findings reflex to manual differential.

Lab - Urine

Procedure	Units	Reference Range	Collected Date Collected Time 2/2/2023 11:06 EST
Urine Appearance			CLEAR[O6]
Urine Color			YELLOW[O6]
Urine Glucose		[NEG]	NEGATIVE[O6]
Urine Bilirubin		[NEG]	NEGATIVE[O6]
Urine Ketones		[NEG]	NEGATIVE[O6]
Urine Specific Gravity		[1.005-1.030]	1.025[O6]
Urine Blood		[NEG]	NEGATIVE[O6]

Report Request ID: 987654321 Requester: BENNETT, CLARA

Lab - Results

Lab - Urine

Collected Date: 2/2/2023 Collected Time: 11:06 EST

Procedure	Units	Reference Range	Result
Urine pH		[5.0-8.5]	5.5
Urine Protein		[NEG]	TRACE (ABN)
Urine Urobilinogen	mg/dL	[0.0-1.0]	NEGATIVE
Urine Nitrite		[NEG]	NEGATIVE
Urine Leukocyte Esterase		[NEG]	NEGATIVE
Urine RBCs	/HPF	[<2]	See Below

Textual Results T1: 2/2/2023 11:06 EST (Urine RBCs) CRITERIA NOT MET FOR MICROSCOPIC EXAM

Order Comments O6: Urinalysis with Microscopic Exam Collect urine specimen. This does NOT include a urine culture. Note: If chemical positive, reflex to microscopic exam.

Lab - Bloodbank

Collected Date: 2/2/2023 Collected Time: 09:56 EST

Procedure	Units	Reference Range	Result
Type And Screen			See Below

Textual Results T2: 2/2/2023 09:56 EST (Type And Screen) BLOOD COMPONENT TYPE: RED CELLS CROSSMATCH EXPIRATION: 02/09/2023 ABO/RH(D): B POSITIVE ANTIBODY SCREEN: NEGATIVE ABD TECHNIQUE: PERFORMED BY GEL METHOD

Order Comments O7: Type and Screen Collect 1 full pink top EDTA tube Witness: verifies two patient identifiers using the patient's wristband against the CIS Order/ Specimen label and the requisition and must sign their full name and title on the requisition in the presence of the patient. Phlebotomist: must sign their full name and title on the requisition and specimen label in the presence of the patient. Indicate the time and date of phlebotomy on the requisition. Blood bank samples must be signed with the matching full legal signature of the phlebotomist on the requisition. Initials, printed names and mismatched signatures will not be accepted. If additional units are ordered within 72 hours and are on the same

encounter, the original specimen can be used to complete the crossmatch, you do not need to redraw the patient. Write "Specimen in Lab" on the requisition. If ordering a transfuse volume of less than one unit, indicate the number of mL's in the field name "No. of mLs to transfuse."

Report Request ID: 987654321 Requester: BENNETT, CLARA Printed On: 3/7/2023 14:17 EST Page 25 of 84 27 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Lab - Documents

DOCUMENT NAME: Type And Screen SERVICE DATE/TIME: 2/2/2023 09:56 EST RESULT STATUS: Modified PERFORM INFORMATION: Central Plains Medical Center,789 Oak Avenue,Omaha NE 68102 (2/2/2023 09:55 EST)

SIGN INFORMATION:

TYPE AND SCREEN BLOOD COMPONENT TYPE: RED CELLS CROSSMATCH EXPIRATION: 02/09/2023 ABO/RH(D): B POSITIVE ANTIBODY SCREEN: NEGATIVE ABD TECHNIQUE: PERFORMED BY GEL METHOD

Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT,CLARA Page 26 of 84

Back to top 28 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023

FIN: DE9876543210

Progress Notes

DOCUMENT NAME: Brief Incident Note SERVICE DATE/TIME: 2/8/2023 06:39 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: REED MD, EVELYN (2/8/2023 06:40 EST) SIGN INFORMATION: REED MD, EVELYN (2/8/2023 06:40 EST) AUTHENTICATED BY: REED MD, EVELYN (2/8/2023 06:40 EST)

Central Plains Medical Center MLP Brief Incident Note "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This

document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Patient: MILLER, ARTHUR MRN: M-0101123456 FIN: DE9876543210 Age: 57 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: None Author: REED MD, EVELYN

Document Created Document Creation: 02/08/23 06:39 .

Date of Service Date of Service: 02/08/2023.

Incident Summary Upon discharge from the hospital, the patient will be level/ room confined and will require an elevated bedside commode with adjustable legs in order to maintain posterior hip dislocation precautions during recovery/ rehabilitation from surgery.

Health Status Problem list:

- All Problems
  - Avascular necrosis of hip / 2920805015 / Confirmed

Professional Services Creator Information:

- Participation I spent 5 minutes with the patient.
- MLP Role Collaborating w Affiliated Network Physician. Creator Information: Evelyn Reed MD, Beeper number (555) 123-4567 Ext. 8910, Physician.
- MLP Role Acting in collaboration with Central Plains Employed Physician.

- MLP Role Acting in collaboration with Central Plains Employed Physician.

DOCUMENT NAME: Progress Note SERVICE DATE/TIME: 2/9/2023 08:47 EST RESULT STATUS: Unauthenticated/Unsigned PERFORM INFORMATION: VANCE, ELEANOR LCSW (2/9/2023 14:47 EST) SIGN INFORMATION: VANCE, ELEANOR LCSW (2/9/2023 14:47 EST) AUTHENTICATED BY:

Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 27 of 84

Back to top 29 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023

FIN: 987654321098

Progress Notes

Metro Health & Wellness Progress Note "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Patient: MILLER, ARTHUR MRN: M-123456789 FIN: 987654321098 Age: 57 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: None
Author: VANCE LCSW, ELEANOR

Document Created Document Creation: 02/09/23 14:47 .

Date of Service Date of Service: 02/09/2023.

Basic Information 57 yo pt s/p L THA on 2/8/23

Subjective Patient seen this morning resting comfortably in bed. No acute events overnight. Patient is having appropriate post-op pain, pain is tolerable with medications. Patient tolerating oral intake and using IS. Patient denies numbness/ paresthesias, no SOB/CP/N/V.

Health Status Current medications

Active Inpatient Medications

Scheduled Medications:

acetaminophen (Tylenol) 1,000mg = 2Tab By Mouth Q8H aspirin 81mg = 1 Tab By Mouth BID w Food docusate (Colace) 100mg = 1 Cap By Mouth Q12 multivitamin 1 Tab By Mouth Daily Nozin nasal sanitizer 1Appl Nostrils, Both PREOF pantoprazole (Protonix) 40mg = 1Tab By Mouth Daily polyethylene glycol 3350 (MiraLax) 17gm = 1Pkt By Mouth Daily senna 17.2mg = 2Tab By Mouth QHS sodium chloride (Normal Saline Flush) 3mL IV PUSH Q8

Active PRN Medications:

acetaminophen-HYDROcodone (Norco 10 mg-325 mg oral tablet) 1 Tab By Mouth Q4 al hydroxide/Mg hydroxide/simethicone (Maalox) 30mL By Mouth ACandHS benzocaine-menthol topical (Cepacol Sore Throat (benzocaine-menthol 15 mg-3.6

mg) mucous membrane lozenge) 1 Lozenge By Mouth Q2 cyclobenzaprine (Flexeril) 5mg = 1Tab By Mouth TII diphenhydrAMINE (Benadryl) 25mg = 1 Cap By Mouth TIE

Progress Notes

ketorolac (TORADol) 30mg = 1mL IV PUSH Q6 H magnesium hydroxide (MOM) 30mL By Mouth QHS naloxone (narCAN) 0.4mg = 1mL IV PUSH Q2MIN ondansetron (Zofran) 4mg = 2mL IV PUSH Q4 sodium chloride (saline flush for tubing) 3mL IV PUSH Unscheduled sodium chloride (Normal Saline Flush) 10mL IV PUSH Unscheduled

One Time Medications in the past 36 hours:

(Completed) 02/08/23 13:22:00 EST famotidine 20mg = 1 Tab By Mouth One Time Only

Continuous Infusions:

Sodium Chloride 0.9% 1,000 mL 1,000mL IV INFUSION 100 mL/hr Sodium Chloride 0.9% 1,000 mL 1,000mL IV INFUSION 100 mL/hr

Problem list: All Problems At risk for falls / 208683018 / Confirmed Avascular necrosis of hip / 2920805015 / Confirmed

Objective VS/Measurements

Most recent Vital Signs last 24 hours: Temperature: 37.2 using method Oral BP: 139/73 Pulse: 92 Respiration Rate: 16 SpO2: 98 FIO2: --- 24Hr Tmax: 37.2 using method Oral

Weight: Initial Weight: 72.9 kg 160 lb 02/02 Current Weight: 72.0 kg 158 lb 02/08

General: Alert and oriented, No acute distress. HENT: Normocephalic, Atraumatic. Respiratory: Respirations are non-labored. Cardiovascular: Good pulses equal in

all extremities, Normal peripheral perfusion. Gastrointestinal: Soft. Musculoskeletal BLE:

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023

FIN: 987654321098

Progress Notes

- Left hip dressing clean, dry and intact
- SILT at DP/SP/tibial nerve distributions
- Motor intact at EHL/FHL/GSC/TA
- Capillary refill < 2 seconds, 2+ DP pulse. Neurologic: Alert, Oriented. Psychiatric: Cooperative, Appropriate mood & affect.

Quality and Safety Quality and Safety: At risk for falls: 02/09/2023 07:00 EST Core Measures Indwelling Urethral Catheter Indication (Patient does not have an indwelling urethral catheter), and Central Venous Catheter Indication (Patient does not have a central venous catheter).

Impression and Plan 51 yo M s/p L THA on 2/8/23

-Medical management per IM -WBAT -PT/OT consult for ambulation and gait training -Perioperative antibiotics ordered -Post Operative X rays reviewed -Diet Regular -Home meds ordered -Dressing changed POD 2 -Bowel regimen ordered -DC foley POD1 -DVT prophylaxis ordered

Dispo: Plan for DC when pain is well controlled with PO pain meds and patient passes PT

Created by Eleanor Vance, LCSW Wellness Services

DOCUMENT NAME:	**Progress Note**
SERVICE DATE/TIME:	2/9/2023 11:37 EST
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	VANCE PhD,ELARA (2/9/2023 11:40 EST)
SIGN INFORMATION:	VANCE PhD,ELARA (2/9/2023 11:40 EST)
AUTHENTICATED BY:	VANCE PhD,ELARA (2/9/2023 11:40 EST)

Central Plains Medical Center Consultation progress note "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Progress Notes

Age: 58 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: None Author: VANCE, ELARA MD

Document Created Document Creation: 02/09/23 11:37

Date of Service Date of Service: 02/09/2023. Consulting Service: Internal medicine.

Patient is seen and examined today during the morning rounds, test results and notes reviewed and discussed with the patient and the primary team.

Chief Complaint

The patient is a 58 years old Male weighing 72.0 kg 158 lb.

Referring physician Dr. Alistair Finch, Patient is seen and examined by medicine consultation for medical management and follow-up as per request of the primary team.

History of Present Illness

I performed a thorough and comprehensive history taking from the patient about current circumstances, pain distribution and severity of the pain alleviating and aggravating factors, Medication she is taking, past medical history, The patient is a pleasant 58-year-old male who has had chronic right hip pain secondary to o/a. The patient has failed all conservative measures and therefore has elected to proceed with the above-mentioned procedure. The risks, benefits and alternatives of treatment were discussed with the patient. Some of these risks included, but were not limited to infection, hematoma, DVT, PE, stroke, MI, fracture, dislocation, leg length discrepancy, neurovascular injury and even death. The patient expressed understanding of these risks and elected to proceed with robotic assisted total right hip arthroplasty. Patient activity of daily living being limited by the pain, patient takes analgesic treatment frequently, Patient was qualified for the procedure to reduce his symptoms of the pain and to improve his quality of life, he will be admitted to the floor to monitor his vital signs, pain control, he will be assisted by PT OT with the orthopedic team supervision, Will monitor vital signs, blood work-up, fluid balance, abnormal metabolic disorder to be corrected as needed, Patient is encouraged for more ambulation and to use incentive spirometer, Will continue on GI and DVT prophylaxis.

Post-Operative diagnosis

Osteoarthritis of right hip (ICD10-CM M16.11, Admitting, Medical).

Procedure performed

Right Total Hip Arthroplasty.

Histories

Past Medical History: Active Avascular necrosis of hip (2920805015) Comments:

Report Request ID: 987654321 Requester: BENNETT, CLARA Printed On: 3/7/2023 14:17 EST Page 31 of 84 33 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Progress Notes 01/18/2023 EST 08:00 EST - JENKINS RN, SARAH Right Family History: No family history items have been selected or recorded. Procedure History: Joint device (implantable) (C1776) on 02/08/2023 at 57 Years. Joint device (implantable) (C1776) on 02/08/2023 at 57 Years. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with o (99284) on 11/29/2019 at 53 Years. Administration of diphtheria-tetanus-pertussis, combined (99.39) on 07/10/2011 at 45 Years. Removal procedure (444298017) in 2005 at 39 Years. Comments: 01/18/2023 08:21 EST - JENKINS RN, SARAH "Knot on penis" Social History

Social & Psychosocial Habits

Alcohol 01/18/2023 Use: Current Type: Beer, Wine Frequency: 1-2 times per month Comment: Instructed not to drink alcohol 24 hours prior to surgery - 01/18/2023 08:26 - JENKINS RN, SARAH

Home/Environment 01/18/2023 Lives with: With Spouse Living situation: Home/ Independent Family/Friends available to help: Yes Human Trafficking Red Flags: None

Substance Abuse 01/18/2023 Use: Current Type: Marijuana Frequency: Daily Comment: Instructed not to smoke 24 hours prior to surgery - 01/18/2023 08:26 - JENKINS RN, SARAH

Tobacco 01/18/2023 Use: Current some day smoker Type: Cigars Comment: Instructed not to smoke 24 hours prior to surgery - 01/18/2023 08:22 - JENKINS RN, SARAH Family history is positive hypertension, overweight, dyslipidemia and osteoarthritis.

Review of Systems Musculoskeletal: Joint pain. All other systems are negative

Physical Examination VS/Measurements

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: AM1234567890

Progress Notes

Most recent Vital Signs last 24 hours:

Temperature: 36.8 using method Oral BP: 150/83 Pulse: 83 Respiration Rate: 17 SpO2: 96 FIO2: --- 24Hr Tmax: 37 using method Temporal

Weight:

Initial Weight: 72.9 kg 160 lb 02/02 Current Weight: 72.0 kg 158 lb 02/08

General: Alert and oriented, Well nourished, Well developed, No acute distress. Eye: Pupils are equal, round and reactive to light, Intact accommodation, Normal conjunctiva, visual disturbance since last 4-5 months. HENT: Normocephalic, Atraumatic, Normal hearing, Oral mucosa is moist. Respiratory: Lungs CTA bilaterally, No wheeze, Respirations are non-labored. Cardiovascular: Regular rate, Regular rhythm, S1 auscultated, S2 auscultated, No edema. Gastrointestinal: Soft, Non-distended, BLE mild tenderness. Musculoskeletal: Patient has a dressing on the I site of surgery, no obvious bleeding or drainage, decrease range of motion, Integumentary: Warm, Dry, Intact. Neurologic: Alert, Oriented, Normal sensory, Normal motor function, No focal defects. Psychiatric: Cooperative, crying on and off while having conversation with the patient

Impression and Plan

Post-Operative diagnosis Osteoarthritis of right hip (ICD10-CM M16.11, Admitting, Medical). Procedure performed Right Total Hip Arthroplasty.

I performed a comprehensive physical exam on the patient including all systems, A comprehensive medical decision making, I reviewed patient medical record, EKG, chest x-ray, blood work-up, Cardiac clearance,

Report Request ID: 789012345 Printed On: 4/15/2024 09:30 CST Requester: BENNETT, CLARA Page 33 of 84

Back to top 35 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: DE9876543210

Progress Notes

Patient is making good progress today, walking distance with a walker and assistant from PT OT has improved, Range of motion of the hip as well, Inspection

of site of surgery shows no complication, Patient is hemodynamically stable no fever no hypoxia,

I discussed patient about discharge instruction, medication, medical follow-up, patient was encouraged to call for medical question,

-Hyperglycemia, blood sugar 170 mg/dL, No history of diabetes mellitus, discussed with patient to follow-up with primary care doctor, check hemoglobin A1c, modified type of diet,

-Leukocytosis, WBC 13.2 K, Finding is probably reactive to surgery, patient clinical exam shows no evidence of infection, no fever, Encourage activity, deep breathing, no antibiotic treatment is needed,

-Normocytic anemia, hemoglobin 11.4 g, Finding is probably related to some blood loss during surgery, side effect of IV fluid, site of surgery shows no bleeding, patient is asymptomatic, Follow-up with repeated H&H and iron study as outpatient,

-Acute right hip pain secondary to right total hip arthroplasty, Is improving, post op care and pain control per Ortho team, Continue local care, follow with the instruction of physical occupational therapist with supervision of orthopedic team. Resume medication prescribed by orthopedic team.

-Few readings of elevated blood pressure without history of hypertension, Will continue to monitor vital signs, electrolytes, fluid balance, pain and nausea symptoms,

-Bradycardia, Heart rate 70-80 bpm, Is mild patient has few readings of low heart rate, Is probably reactive to a vagal reflex from anesthesia and surgery, will continue to follow vital signs, electrolytes, no additional treatment is needed, patient is asymptomatic.

-History of dyslipidemia, No records available, patient can check lipid profile and liver function test with primary care doctor to discuss about risk factor diet modification of lifestyle diet and activity.

-GERD, Described as occasional and mild by the patient, discussed about the PPI treatment, modification of diet and timing of the meal.

-Tobacco dependence/marijuana use, Discussed with patient about potential risk and complication and availability of medical treatment and counseling, nicotine patch,

Back to top 36 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: BENNET, ELIZABETH Admit Date: 2/8/2023

FIN: DE9876543210

Progress Notes

Will keep oxygenation within normal range, encouraged use of incentive spirometer,

-Vitamin D deficiency, Continue p.o. supplement, follow with the serum level as outpatient.

-Debility, Secondary to above and the recent right total hip arthroplasty, patient will be assisted by PT OT and orthopedic team for activity of daily living.
-Encouraged ambulation and the use of incentive spirometer.

-GI and DVT prophylaxis.

Thanks for the consultation we will follow with you.

Created by Dr. Elara Vance Beeper number 555-0101. Service Internal medicine. Attending.

Back to top 37 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Radiology Report

ACCESSION EXAM DATE/TIME PROCEDURE ORDERING PROVIDER DX230032534^ 2/8/2023 16:27 EST Pelvis-(A-P/P-A) SHARMA NP, ANYA S

Pelvis-(A-P/P-A): 2/8/2023 4:27 PM

CLINICAL HISTORY: 51 years old Male with s/p THA TECHNIQUE: AP view of the pelvis, portable. COMPARISON: 9/15/2022. FINDINGS: Right hip arthroplasty with prosthesis in good position and alignment. Postsurgical soft tissue changes around. Left hip, Sl joints and symphysis pubis are unremarkable. IMPRESSION: Right hip prosthesis in good position and alignment.

FINAL Dictated By: And Verified By: THORNE, ELIAS PhD, LCSW Electronically Signed Date: 02/08/23 16:44 Date Transcribed: PWS 02/08/23 16:43

Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 36 of 84 38 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 09/01/2023 - 09/15/2023

Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 10/15/2023

Surgical Documents

DOCUMENT NAME: Postprocedure Education SERVICE DATE/TIME: 10/15/2023 16:32 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: BARTON RN,CLARA (10/15/2023 16:32 EST) SIGN INFORMATION: AUTHENTICATED BY:

Postprocedure Education 10/15/23 16:32 EST Performed by BARTON RN, CLARA Entered on 10/15/23 16:33 EST

Education

Education History Results

Procedure Type: right THA Topic: Anesthesia/Sedation, Anxiety Reduction Techniques, Infection prevention, Infection Prevention: Surgical Site Infection Prior to Proce, Medication instructions, Need for overnight adult supervision, Pain management, Peri-Op Plan of Care: Infection, Inju... Individuals Taught: Patient Barriers to Learning: None Teaching Method: Verbal Teaching Evaluation: Met Comment: has no further questions Performed by: PETROVA RN, ANASTASIA - 10/15/23 12:52:00

Topic: Infection prevention, Leave valuables at home, Medication instructions, NPO instructions, Preprocedure Prep, Preprocedure tests/labs, Surgery date/time/ location reviewed Individuals Taught: Patient Barriers to Learning: None Teaching Method: Explanation, Teach Back, Verbal, Written/Handouts Teaching Evaluation: Met Comment: Preop instruction given and Reviewed --09/01/2023 Alice Smith PCA. Performed by: JENKINS RN, SARAH - 09/01/23 10:04:00

Procedure Type: Preop Topic: Family instructions, Infection prevention, Leave valuables at home,

Report Request ID: 987654321 Printed On: 11/28/2023 09:30 EST Requester: BENNETT, CLARA Page 55 of 99

Back to top 39 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 09/10/2024 - 09/25/2024

Patient Name: MILLER, ARTHUR Admitted: 09/15/2024 FIN: 987654321098

Surgical Documents

Medication instructions, Pain management, Preprocedure diet, Spoke with patient/family about concerns, Surgery date/time/location reviewed Individuals Taught: Patient Barriers to Learning: None Teaching Method: Printed materials, Teach Back, Telephone Teaching Evaluation: Met Comment: Medical Center Preop # given arrival time 1000. talk to patient JR Performed by: JENKINS RN, SARAH - 08/15/24 14:30:00

Postprocedure Education Grid

1. Procedure Type Right THA Postprocedure Education Topics Discharge planning, Infection prevention, Peri-Op Plan of Care: Infection, Injury, Anxiety, Body Image Individuals Taught Patient, Friend Barriers to Learning None Teaching Method Explanation, Verbal Teaching Evaluation Follow-Up Needed, Teaching Ongoing Comment: pt and friend verbalized understanding. no further questions

Learning Needs

| Readiness to Learn Assessment | Asks questions | | Barriers to Learning Rehab | None evident |

DOCUMENT NAME: Anesthesia SERVICE DATE/TIME: 09/10/2024 11:00 CST RESULT STATUS: Unauthenticated/Unsigned PERFORM INFORMATION: THORNE MD-Physician, ELIAS (09/10/2024 11:15 CST) THORNE MD-Physician, ELIAS (09/10/2024 11:16 CST); THORNE MD-Physician, ELIAS (09/10/2024 11:15 CST)

SIGN INFORMATION:

AUTHENTICATED BY:

PAT clinic note "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Patient: MILLER, ARTHUR MRN: H-987654321 FIN: 987654321098

Age: 59 years Sex: Male DOB: 05/21/1965

Associated Diagnoses: None

Report Request ID: 987654321 Printed On: 10/20/2024 16:05 CST Requester: BENNETT, CLARA Page 38 of 84

Back to top 40 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023

FIN: 9876543210

Surgical Documents

Author: THORNE MD-Physician, ELIAS

Document Created Document Creation: 02/02/23 09:56

Age: 58y Height: 167.6cm Weight: 72.4 BMI: 25.8

Date of surgery: 02/08/23 Surgeon: FINCH MD, ALISTAIR Surgical Procedure: Right total hip arthroplasty

PMH: None PSH: None Social history: Marijuana smoker (3-4 times a week), occasional alcohol use, denies any illicit drug use Allergy: None Medications: Tylenol Unstable medical conditions: None ASA status: 2 Surgical risk : intermediate RCRI: 0, 3.9% risk (based on Cr from 2018) MICA score: 0.1%

Dukes physical activity scale: 30.2 points, 6.45 METS STOP BANG: low risk Preop labs : pending

Recent cardiac testing/ procedures:

EKG: 01/20/23: Sinus rhythm, normal rate, no ST elevations, QT 331 ECHO: None Stress Test: None

Back to top 41 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: DE9876543210

Surgical Documents

Coronary Angio: None AICD/PPM: None Type: None last interrogated: None

Assessment & Plan

- #Pre-Surgical Evaluation list surgery
- -- Surgical risk level: High
    - Functional Status: METS >4

- -Revised Cardiac Risk Index (RCRI) for Pre-Operative Risk: 0
- -- labs pending
- -- Inform patient to take all of her meds on the day of the surgery with a sip of water prior coming to the hospital
- Medications to be withheld on day of surgery
- -- Plan of care discussed with team and patient.
- -- Patient cleared for surgery, pending labs results,
- -- Patient requires optimization and clearance from: Cleared by PCP

Education: Smoking cessation: Counseled Prehabilitation: None OSA management: None Date of Service Date of Service: 02/02/2023.

Preoperative Information

Revised cardiac risk index: Elevated-risk surgery (Intraperitoneal; intrathoracic; suprainguinal vascular): No. Back to top 42 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: DE9876543210

Surgical Documents

History of ischemic heart disease (History of myocardial infarction, history of positive exercise test, current chest pain considered due to myocardial ischemia, use of nitrate therapy or ECG with pathological Q waves): No. History of cerebrovascular disease (Prior TIA or stroke): No. Pre-operative treatment with insulin: No. Pre-operative creatinine >2 mg/dL: No. Risk for major cardiac complications based on number of above answered yes: 0 (0.4%). Metabolic equivalents: METS >=4. PONV risk score: Female gender: No. Nonsmoker: No. History of motion sickness or PONV: No. Expected postoperative opioids: Yes. PONV risk based on number of above answered yes: 1 (20%). Anesthesia history: Patient history: Unremarkable. Family history: Unremarkable. Blood information Health Status Allergies: Allergic Reactions (Selected) No Known Allergies Current medications No known home medications exist for this patient. No inpatient medications have been documented for this encounter Problem list: All Problems Avascular necrosis of hip / 2920805015 / Confirmed Histories Past Medical History: Active Avascular necrosis of hip (2920805015) Comments: 01/18/2023 EST 08:00 EST - JENKINS RN, SARAH Right Procedure history: Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with o (99284) on 11/29/2019 at 47 Years. Administration of diphtheria-tetanus-pertussis, combined (99.39) on 07/10/2011 at 39 Years. Removal procedure (444298017) in 2005 at 34 Years. Comments: 01/18/2023 08:21 EST JENKINS RN, SARAH "Knot on penis" Social History Report Request ID: 987654321 Printed On: 4/15/2024 10:30 PST Requester: BENNETT, CLARA Page 55 of 110 Back to top 43 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023

Patient Name: MILLER, ARTHUR	**Admit Date: 2/8/2023**
FIN:	DE9876543210

Surgical Documents

Social & Psychosocial Habits

Alcohol 01/18/2023 Use: Current Type: Beer, Wine Frequency: 1-2 times per month Comment: Instructed not to drink alcohol 24 hours prior to surgery - 01/18/2023 08:26 - JENKINS RN, SARAH Home/Environment 01/18/2023 Lives with: Alone

Living situation: Home/Independent Family/Friends available to help: Yes Human Trafficking Red Flags: None Substance Abuse 01/18/2023 Use: Current Type: Marijuana Frequency: Daily Comment: Instructed not to smoke 24 hours prior to surgery 01/18/2023 08:26 - JENKINS RN, SARAH Tobacco 01/18/2023 Use: Current some day smoker Type: Cigars Comment: Instructed not to smoke 24 hours prior to surgery - 01/18/2023 08:22 - JENKINS RN, SARAH

Physical Examination

VS/Measurements No vitals have been documented for this encounter over the last 24 hours Respiratory: Respirations are non-labored, Breath sounds are equal, Symmetrical chest wall expansion, No chest wall tenderness. Breath sounds: Bilateral. Cardiovascular: Normal rate, Regular rhythm, No murmur, No gallop, Good pulses equal in all extremities, Normal peripheral perfusion, No edema. Gastrointestinal: Soft, Non-tender, Non-distended, Normal bowel sounds, No organomegaly. Neurologic: Alert, Oriented, Normal sensory, Normal motor function, No focal deficits. Airway Assessment: Dentition: Intact, Upper denture. Mallampati Classification: Mallampati III. Neck ROM: Full ROM. Mouth opening: >5cm. Thyromental Distance: >6cm. Upper Lip Bite Test: Class 2. Based on assessment airway appears to be: Possibly difficult. Obstructive Sleep Apnea Assessment: Male sex.

Plan

Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098 Surgical Documents American Society of Anesthesiologists#(ASA) physical status classification: Class II. Anesthetic Preoperative Plan Anesthesia: Regional Spinal. Anesthetic plan, risks, benefits, and alternatives discussed with the patient and/or family. Risks discussed: nausea, vomiting, headache, sore throat, dental injury. Patient verbalized understanding. Informed consent was given. Created by Dr. Elias Thorne First Year Resident Extension# 5501 DOCUMENT NAME: Anesthesia SERVICE DATE/TIME: 2/7/2023 07:27 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: O'CONNELL MD, LIAM (2/7/2023 07:28 EST) SIGN INFORMATION: THORNE MD, ELIAS (2/8/2023 06:53 EST); O'CONNELL MD, LIAM (2/7/2023 07:28 EST) AUTHENTICATED BY: THORNE MD, ELIAS (2/8/2023 06:53 EST) PAT clinic note

> "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for

physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Patient: MILLER, ARTHUR MRN: C-987654321 FIN: 987654321098 Age: 57 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: None Author: O'CONNELL MD, LIAM Document Created Document Creation: 02/07/23 07:28 Age: 57y Height: 167.6cm Weight: 72.4 BMI: 25.8 Date of surgery: 02/08/23 Surgeon: FINCH MD, ALISTAIR Surgical Procedure: Right total hip arthroplasty PMH: None PSH: None Social history: Marijuana smoker (3-4 times a week), occasional alcohol use, denies any illicit drug use Allergy: None Medications: Tylenol Report Request ID: 555123789 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 43 of 84 45 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: 987654321 Admit Date: 03/15/2023

Surgical Documents

Unstable medical conditions: None ASA status: 2 Surgical risk : intermediate RCRI: 0, 3.9% risk (based on Cr from 2018) MICA score: 0.1% Dukes physical activity scale: 30.2 points, 6.45 METS STOP BANG: low risk Preop labs : pending Recent cardiac testing/ procedures: EKG: 02/28/2023: Sinus rhythm, normal rate, no ST elevations, QT 331 ECHO: None Stress Test: None Coronary Angio: None AICD/ PPM: None Type: None last interrogated: None Assessment & Plan

Pre-Surgical Evaluation list surgery

- Surgical risk level: High
- Functional Status: METS >4
- Revised Cardiac Risk Index (RCRI) for Pre-Operative Risk: 0
- labs pending
- Inform patient to take all of her meds on the day of the surgery with a sip of water prior coming to the hospital
- Medications to be withheld on day of surgery
- Plan of care discussed with team and patient.

Back to top Patient Name: MILLER, ARTHUR FIN: DE9876543210 Admit Date: 07/16/2024

Surgical Documents

- Patient cleared for surgery, pending labs results,
- Patient requires optimization and clearance from: Cleared by Treating Physician

Education: Smoking cessation: Counseled Prehabilitation: None OSA management: None Date of Service Date of Service: 07/15/2024. Preoperative Information Revised cardiac risk index: - Elevated-risk surgery (Intraperitoneal; intrathoracic; suprainguinal vascular): No. - History of ischemic heart disease (History of myocardial infarction, history of positive exercise test, current chest pain considered due to myocardial ischemia, use of nitrate therapy or ECG with pathological Q waves): No. - History of cerebrovascular disease (Prior TIA or stroke): No. - Pre-operative treatment with insulin: No. - Pre-operative creatinine > 2 mg/dL: No. - Risk for major cardiac complications based on number of above answered yes: 0 (0.4%). Metabolic equivalents: METS >=4. PONV risk score: - Female gender: No. - Nonsmoker: No. - History of motion sickness or PONV: No. - Expected postoperative opioids: Yes. - PONV risk based on number of above answered yes: 1 (20%). Anesthesia history: - Patient history: Unremarkable. - Family history: Unremarkable. Blood information Health Status Allergies: - Allergic Reactions (Selected) - No Known Allergies Report Request ID: 987654321 Printed On: 08/20/2024 10:30 PST Requester: BENNETT, CLARA Page 45 of 84 47 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321 Surgical Documents Current medications No known home medications exist for this patient. Active Inpatient Medications Scheduled Medications: acetaminophen 1,000mg = 2Tab By Mouth PREOF ceFAZolin (Ancef) 2gm = 100mL IVPB PREOF celecoxib (CeleBREX) 200mg = 1Cap By Mouth PREOF gabapentin 600mg = 1Tab By Mouth PREOF Noz in nasal sanitizer 1Appl Nostrils, Both PREOF vancomycin (vancomycin-surg prophy, high MRSA rate) 1,500mg = 275mL IVPB PREOF Active PRN Medications: sodium chloride (saline flush for tubing) 3mL IV PUSH Unscheduled Problem list: All Problems Avascular necrosis of hip / 2920805015 / Confirmed Histories Past Medical History: Active Avascular necrosis of hip (2920805015) Comments: 01/18/2023 EST 08:00 EST - JENKINS RN, SARAH Right Procedure history: Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with o (99284) on 11/29/2019 at 47 Years. Administration of diphtheria-tetanus-pertussis, combined (99.39) on 07/10/2011 at 39 Years. Removal procedure (444298017) in 2005 at 34 Years.

Comments: 01/18/2023 08:21 EST - JENKINS RN, SARAH "Procedure on extremity" Social History Social & Psychosocial Habits Alcohol 01/18/2023 Use: Current Type: Beer, Wine Frequency: 1-2 times per month Comment: Instructed not to drink alcohol 24 hours prior to surgery - 01/18/2023 08:26 - JENKINS RN, SARAH Home/ Environment 01/18/2023 Lives with: Alone Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 46 of 84 48 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Surgical Documents

Living situation: Home/Independent Family/Friends available to help: Yes Human Trafficking Red Flags: None Substance Abuse - 01/18/2023 Use: Current - Type: Marijuana - Frequency: Daily - Comment: Instructed not to smoke 24 hours prior to surgery - 01/18/2023 08:26 - JENKINS RN, SARAH Tobacco - 01/18/2023 Use: Current some day smoker - Type: Cigars - Comment: Instructed not to smoke 24 hours prior to surgery - 01/18/2023 08:22 - JENKINS RN, SARAH Physical Examination VS/Measurements No vitals have been documented for this encounter over the last 24 hours Respiratory: Respirations are non-labored, Breath sounds are equal, Symmetrical chest wall expansion, No chest wall tenderness. Breath sounds: Bilateral. Cardiovascular: Normal rate, Regular rhythm, No murmur, No gallop, Good pulses equal in all extremities, Normal peripheral perfusion, No edema. Gastrointestinal: Soft, Non-tender, Non-distended, Normal bowel sounds, No organomegaly. Neurologic: Alert, Oriented, Normal sensory, Normal motor function, No focal deficits. Airway Assessment: - Dentition: Intact, Upper denture. - Mallampati Classification: Mallampati III. - Neck ROM: Full ROM. - Mouth opening: >5cm. - Thyromental Distance: >6cm. - Upper Lip Bite Test: Class 2. - Based on assessment airway appears to be: Possibly difficult. - Obstructive Sleep Apnea Assessment: Male sex. Plan American Society of Anesthesiologists#(ASA) physical status classification: Class II. Anesthetic Preoperative Plan Anesthesia: Regional Spinal. Anesthetic plan, risks, benefits, and alternatives discussed with the patient and/or family. Risks discussed: nausea, vomiting, headache, sore throat, dental injury. Patient verbalized understanding. Informed consent was given. Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 47 of 84 [Back to top](#) ANESTHESIA INTRAOPERATIVE RECORD [ ] CPC [ ] CGH [ ] SPM [ ] B/La [ ] OSM ASA 1 [ ] [ ] [ ] 5 [ ] 6 [ ] E [ ] Past Medical History: (Signature area) Auth (Verified) (Barcode area) 071 FIN: 987654321098 MILLER, ARTHUR 05/21/1965 M AMSHHQ// PCP: VANCE MD, ELIAS ATTN: FINCH MD, ALISTAIR PTID: 98765432 MRN: XXXXX9012 DOS: 2 3 0 5 5 0 3 0 5 P 0 0 0 0 0 0 0 8 6 1 Date of Procedure: 03/15/24 Surgeon: Finch PreOp

Meds: Allergies: (Signature area) [x] Identity Verify [x] Consent Sig [x] Site Confirmed OR/Location: 8 PreOp Vitals: Font 100 versal [ ] Inpatient [ ] Outpatient [ ] Same Day Add On [ ] Age: 59 Wt: 80 Ht: NPO at: 85 AGENTS/DRUGS

Medications	**TIME 1**	**2**	**3**	**4**	**5**	**TOTAL**
Oxygen Liters/Min	10	10	10	10	10	10
Air/N_2O Liters/ Min	0	0	0	0	0	0
Des						
Sevo						
Iso						
Fentanyl mg						
Lidocaine mg						
Propofol mg	90-100	-150	-100			1000
Ketamine mg						
Sux / Roc / Vec mg						
Decadron mg		8				
Benadryl mg		25				
Zotvan		4				

Induction/Block Note: Sternite Prep Level Needle 22 Midline [x] Paramed. Attempts: 1 GEN [ ] MAC [ ] SPN [ ] EPID [x] Block Dose: Drug/Lcl: Fent 15 Hern [ ] Paresthesia [ ] PCCSF Beta Blockers: (Signature area) IV Abx: Aneef/Vanco Dose: Time: 03/15/24 1420 PIV 20g RX [x] [ ] [ ] PIV 19g [x] [ ] [ ] Art Line [ ] [ ] [ ] Cent. Line [ ] [ ] [ ] PAC [ ] [ ] [ ] inSitu Phys CRNA TECHNIQUES & MODIFIERS Normal Positions: [x] Supine [ ] Lithotomy [ ] Trendelenburg Unusual Positions: [ ] Prone [x] Lateral R [ ] D [ ] Chair [ ] Other: Field Avoidance: [x] Bed 90/180 [ ] ENT/Face/ Shoulder Surgery [ ] Hypothermia [ ] One Lung [ ] Delib Hypoten. [ ] CPB/VWB PATIENT SAFETY [ ] Circ Arrest [x] Anes. Mach Checked [ ] Chest Rolls [ ] Beanbag [x] Axillary Rolls [x] Safety Belt [x] Press. Pts Padded Lt. Arm: [ ] Tucked [x] Armboard [ ] Eyecare: [ ] Taped [ ] Saline Rt. Arm: [x] Tucked [x] Armboard [ ] Goggles [ ] Ointment MONITORS & EQUIPMENT [x] NIBP on QUEO [ ] BIS [ ] Doppler [ ] Foley [ ] NGT/OGT [x] Forced Warm Air [ ] Fluid Warmer [ ] Other: TEE [ ] Placed Only [ ] Interpretation

	Time 1420 1430 1440 1450 1500 1510 1520
	Preinduction Vitals
O SATURATION %	100 90 98 98 96 98 94 96 100 90 98 98 94
Temp C F	Available
EKG LEAD	SLS LS LS LS LS LS LS LS

% Oz Inspired 100 96 96 95 96 95 96 95 96
END TIDAL CO2 (mm HG) SUSUSUSUSUSU
Tidal Volume
PIP/PEEP
RR Mode
Train of Four
MONITORS
Pre-Oxygenation mm
Re-eval prior to induction Hg
Mask 200
Easy Hard OTESP
Oral.airway cra
Nasal airway PULSE 180
Trach
LMAR NIBP 160
Intubation AUNE
Easy/Hard T ap 140
Oral/Nasal T
Cuffy NX MAP 120
Rapid Seq
Blade Mal Mac 1 2 3 4
ETT size Oral Nasal 100
Attempts 1 2 3 4
View 1 2 3 4 80
Taped: Leak:
ETCO 60
Bilat, Breath sounds 40
Glidescope
FOB# 20
Dbl lumen
HME Humid

FLUIDS URINE OUTPUT ESTIMATED BLOOD LOSS

Discontinuous Start	**Discontinuous End**
Anesthesia End	15:40

Anesthesia Start	In OR Time	In PACU ICU				
13:50	14:03	[ ] [ ]				
Induction	Anesthesia Ready	Full report handoff to RN				
14:07	14:15					
Time Out	Incision/Proc Start	VAS 6/10 Temp	RR	SpO2	O2	Vent
14:36	14:37		15	100	10	SV Tbar Controlled
Surgery End	Out of OR Time					
15:40	15:46					

Comments: Fluids: 800 EBL: 1 Urine: 50 O2: RA NC MS RY NRB Pre Op Diagnosis: Right Hip OA Post Op Diagnosis: Same Procedure(s): Right total Hip Physician present for: [x] Induction [ ] Emergence [x] Regional Block [x] Immediately available for key portions and periodic monitoring Physician Signature: (Signature area) Date: 03/15 Time: 14 Provider ID: 9876 BREAK/LUNCH PROVIDERS

IN	OUT	Last Name & ID	IN	OUT	Last Name & ID
		PHYSICIAN			CRNA
		PHYSICIAN			CRNA
		PHYSICIAN			CRNA

CRNA/Resident Signature: ERS Date: Time: Provider ID: PROVIDER RELIEF PROTOCOL Full report of pre-assessment, intraop plan, and current status, received at: _____ Initials _____ 49638627 (12/18) Original - Medical Records Yellow - Billing Pink - Post Op 50 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Auth (Verified) LEGEND TO SYMBOLS AND ABBREVIATIONS:

ABX	Antibiotics
ART	Arterial Line
ASA	American Society of Anesthesiology
ASA-E	Emergency - in the event of emergency surgery
ASA 1	A normal healthy patient
ASA 2	A patient with a mild systemic disease

ABX	**Antibiotics**
ASA 3	A patient with a severe systemic disease that limits activity, but is not incapacitating.
ASA 4	A patient with an incapacitating systemic disease that is a constant threat to life.
ASA 5	A moribund patient not expected to survive 24 hours with or without surgery
ASA 6	A deceased patient for organ harvesting
BIS	Bispectral Index Monitor
OA	Oak Ave
Cent. Line	Central Venous Catheter
Circ Arrest	Circulatory Arrest Procedure
CPB	CardioPulmonary Bypass
Dbl	Lumen Double Lumen Endotracheal Tube
Delib	Deliberate
Des	Desflurane
CGH	City General Hospital
ECG	Electrocardiogram
ENT	Ear Nose Throat
Eso/Precord	Esophageal / Precordial Stethoscope
ET%	End Tidal % of Gas
ETCO2	End Tidal CO2
FFCCSF	Free flow & clear Cerebrospinal Fluid
FOB	Fiberoptic Bronchoscope
PGH	Prairie General Hospital
HEM	Hematology/Presence of Blood in Catheter
HME	Humid Heat Moisture Exchange Humidifier
OSMC	Oakwood Springs Medical Center
Intraop	Intraoperative
Iso	Isoflurane
LMA	Laryngeal Mask Airway
LOC	Level of Consciousness
MAC	Macintosh Blade
Mach	Machine
MIL	Miller Blade

ABX	Antibiotics
NC	Nasal Cannula
NIBP	Non-invasive Blood Pressure
NGT/OGT	Nasogastric / Orogastric Tube
NRB	Non-Rebreather Mask
OR	Operating Room
PARAMED.	Paramedian Approach
PAC	Pulmonary Artery Catheter
PEEP	Positive End Expiratory Pressure
PIP	Peak Inspiratory Pressure
PIV	Peripheral Intravenous Catheter
PNS	Peripheral Nerve Stimulator
POS	Position
Post Op	Postoperative
Post Op Dx	PostOperative Diagnosis
PHYS	Physician
Proc	Procedure
R L Lat Decub	Right & Left Lateral Decubitus
Rapid Seq	Rapid Sequence Induction
Roc	Rocuronium
RA	Room Air
RR	Respiratory Rate
Sevo	Sevoflurane
Sig	Signature
SPMC	Summit Peak Medical Center
Sux	Succinylcholine
TEE	Transesophageal Echocardiogram
Temp R E S	Temperature - Rectal, Esophageal, Skin
Vec	Vecuronium
VVB	Veno-Veno Bypass

51 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Back to top 52 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 03/14/2024 - 03/20/2024 Patient Name: BENNETT, CLARA FIN: 999888777666555

Admit Date: 03/15/2024

Surgical Documents

DOCUMENT NAME: PreOp Nursing Record SERVICE DATE/TIME: 03/15/2024 11:00 PST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: PETROVA RN, ANASTASIA (03/15/2024 10:00 PST) SIGN INFORMATION: PETROVA RN, ANASTASIA (03/15/2024 10:00 PST) AUTHENTICATED BY:

PreOp Nursing Record SD HA

PreOp Nursing Record SD HA Summary

- Primary Physician: FINCH MD, ALISTAIR
- Case Number: CPA-2024-789
- Finalized Date/Time: 03/15/24 10:30:45
- Pt. Name: BENNETT, CLARA
- D. O. B. /Sex: 05/21/1965 Male
- Med Rec #: 987654321
- Physician: FINCH MD, ALISTAIR
- Financial #: 999888777666555
- Pt. Type: C
- Room/Bed: G
- OPS/03
- Admit/Disch: 03/15/24 08:00:00 -
- Institution:

Case Times PreOp SD HA

	Entry 1	Patient Ready for Surgery
Patient Arrival Time	03/15/24 09:50:00	
Patient Ready for Surgery Time	03/15/24 10:00:00	Yes
Preop Cancel		
Last Modified By:	PETROVA RN, ANASTASIA 03/15/24 10:00:15	

Delays PreOp SD HA

	Entry 1	Duration (In Minutes)
Preop Delay Reason	No Delay	
Last Modified By:	PETROVA RN, ANASTASIA 03/15/24 10:00:20	

Allergies identified in patient's electronic medical record at time of printing on 03/15/24

	Entry 1
Substance	No Known Allergies
Reaction Type	Allergy

Last Modified By: FORD RN, ARTHUR 06/20/15 05:30:22

Finalized By: PETROVA RN, ANASTASIA

Document Signatures

Signed By: PETROVA RN, ANASTASIA 03/15/24 10:00

Surgical Documents

DOCUMENT NAME: IntraOp Nursing Record SERVICE DATE/TIME: 2/8/2023 15:40 EST RESULT STATUS: Modified PERFORM INFORMATION: JOHNSON LCSW, SARAH (2/9/2023 12:28 EST) SIGN INFORMATION: JOHNSON LCSW, SARAH (2/9/2023 12:28 EST); JOHNSON RN, MARK ANTHONY (2/8/2023 15:44 EST) AUTHENTICATED BY: OR Nursing Record SD HA

OR Nursing Record SD HA Summary

Primary Physician: FINCH, ALISTAIR MD Case Number: CMSA-2024-789 Finalized Date/Time: 02/09/23 12:28:08 Pt. Name: MILLER, ARTHUR D. O. B./Sex: 05/21/1965 Male Med Rec #: 987654321 Physician: FINCH, ALISTAIR MD Financial #: 987654321099 Pt. Type: C Room/Bed: 2613/01 Admit/Disch: 02/08/23 04:00:00 - Institution:

Case Times SD HA

Entry 1 Patient Pt. In Room Time 02/08/23 14:03:00 Anesthesia Anes. Start Time 02/08/23 14:03:00 Surgery Surgery Start Time 02/08/23 14:37:00 Set-Up Clean Up Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 15:44:36 Pt. Out Room Time 02/08/23 15:44:00 Anes. Stop Time 02/08/23 15:44:00 Surgery Stop Time 02/08/23 15:40:00

Case Attendance SD HA

Entry 1 Case Attendee: FINCH, ALISTAIR MD Role Performed: Surgeon - Primary Time In: 02/08/23 14:03:00 Time Out: 02/08/23 15:44:00 Pick List: Arthroplasty Total Hip(Right, Hip) Last Modified By: JOHNSON RN, MARK MARK ANTHONY 02/08/23 15:44:40 15:44:46 Entry 2 Case Attendee: THORNE MD, ELIAS Role Performed: Anesthesiologist Time In: 02/08/23 14:03:00 Time Out: 02/08/23 15:44:00 Pick List: Arthroplasty Total Hip(Right, Hip) Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 15:44:40 Entry 3 Case Attendee: O'CONNELL MD, LIAM LIAM Role Performed: Anesthesia Resident Time In: 02/08/23 14:03:00 Time Out: 02/08/23 15:44:00 Pick List: Arthroplasty Total Hip(Right, Hip) Last Modified By: JOHNSON RN, ANTHONY 02/08/23 Entry 4 Case Attendee: SHARMA NP, ANYA S Role Performed: Physician Assistant 1st Entry 5 Case Attendee: THOMPSON, OLIVIA Role Performed: Scrub 1 Entry 6 Case Attendee: JOHNSON RN, ANTHONY Role Performed: Circulator 1 Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 52 of 84 Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 2/8/2023

Surgical Documents Time In Assist 02/08/23 14:03:00 02/08/23 14:03:00 Time Out 02/08/23 14:03:00 02/08/23 15:44:00 02/08/23 15:44:00 Pick List 02/08/23 15:44:00 Arthroplasty Total Arthroplasty Total Arthroplasty Total Hip(Right, Hip) Hip(Right, Hip) Hip(Right, Hip) Last Modified By: JOHNSON RN, MARK ANTHONY JOHNSON RN, MARK ANTHONY JOHNSON RN, MARK 02/08/23 15:44:40 02/08/23 15:44:40 ANTHONY 02/08/23 15:44:46 Delays SD HA Delay Reason Entry 1 Delay Reason Case Ordered Changed Duration (in 93 Minutes) Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 14:42:02 Perioperative Protocols SD HA Entry 1 Patient Identity ID Band Check, Patient Pre Procedure Level Alert, Awake, Verified (select at of Consciousness Oriented least 2) X3 Pre Procedure Mobility Pre-Procedure Team members Limitations Briefing: "All introduced, Blood items must be Products, Implants, addressed. Check Devices and/or special only those that equipment, Specimens, apply" DVT prophylaxsis, Safety precautions, Thermal regulation, Glycemic Beta blockers, lab control, Critical Time Out Time Out values Verified at Time Participants FINCH MD, ALISTAIR, Out: "All items O'CONNELL MD, LIAM, must be addressed. SHARMA NP, ANYA S, Check only those THOMPSON, OLIVIA, that apply" patient position, JOHNSON RN, MARK Accurate and signed ANTHONY procedure consent, Accurate and signed blood consent, Agreement on the procedure to be done, Images/results are labeled/displayed, Antibiotics/meds/fluid irrigations, History and Physical Complete, Fire safety Time Out Complete 02/08/23 14:36:00 Additional Time Out Allergies Allergies, Correct patient identity, Operative/Alternative Site Marked, Correct Report Request ID: 987654321 Printed On: 04/01/2024 10:00 CDT Requester: BENNETT, CLARA Page 53 of 84 55 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098 Surgical Documents

Allergies Reviewed?	**Yes**	**Allergies Reviewed With**	**Patient**
Meds/Solutions Labeled			
Medications Labeled?	N/A	Solutions Labeled?	Yes
Periop Protocols			
Nursing Care Plan Outcome: The patient is free from signs and symptoms of injury.	Yes		
Last Modified By:			

Allergies Reviewed?	**Yes**	**Allergies Reviewed With**	**Patient**
	JOHNSON RN, MARK ANTHONY 02/08/23 14:42:55		

Fire Risk Assessment SD HA Entry 1

Fire Risk Assessment Score		**Surgical Site Above Xiphoid**	**0 - Nc**
Alcohol Based Prep	1 = Yes	Available Ignition Source	1 = Yes
Open Oxygen Source	1 = Yes	Fire Risk Score	3 or greater
Fire Risk Time	02/08/23 14:36:00 High Fire Risk Protocol Initiated	Fire Risk Score CONVERSION:	High
Fire Initiated		Risk Protocol	
Last Modified By:	JOHNSON RN, MARK ANTHONY 02/08/23 14:43:05		

General Case Data SD HA Entry 1

Case Information		**Case Level**	**Level 2**
OR	HA OP E	Specialty	SN Orthopedica
Wound Class	Clean	Trauma Case	Nc
ASA Class	2		
Diagnosis		Postop Same As Preop	Yes
Preop Diagnosis	Right Hip Osteoarthritis.		
Postop Diagnosis	Right Hip Osteoarthritis.		
Humidity Reading (Start of Case)			
Temperature Reading (Start of Case)			
Last Modified By:	JOHNSON RN, MARK ANTHONY 02/08/23 14:43:21		

Skin Assesment SD HA Entry 1

Skin Assessment	**Post-op Skin Condition**	**No changes**
Pre-op Skin Condition	Intact	
Skin Assessment Nursing Care Plan Outcome: The patient is free from signs and symptoms of impaired skin	Yes	

Surgical Documents

integrity. Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 14:43:29 Patient Positioning SD HA Entry 1 Pick List Arthroplasty Total Body Position Lateral Right Hip Right, Hip1 Left Arm Position Secured padded armboard Right Arm Position On padded over the bed armboard, Secured Left Leg Position <90deg per Anes Right Leg Position Flexed Flexed, Eggcrate Under Heel, Eggcrate Under Knee Positioning Devices Arm Board(s), Over the Pressure Points Yes Bed Armboard, Axillary Checked Roll, Gel Pads, Peg Board w/ Padded Pegs, Eggerate Positioned By O'CONNELL MD, LIAM, Safety Strap Back, Chest JOHNSON RN, MARK ANTHONY, Location SHARMA NP, ANYA S Patient Position Nursing Care Plan Outcome: Patient is Yes free from signs and symptoms of injury related to positioning. Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 14:45:05 General Comments: Pt. in left lateral position, safety belt goes from back to chest and allows for chest rise and fall. Skin Prep SD HA Entry 1 Pick List Arthroplasty Total Hip Right, Hip1 Hair Removal Hair Clipped in the No OR Skin Prep Surgical Prep Done Yes Prep Solution Dry Yes Pooling of Prep No Prep Agents Alcohol, Chloraprep Solution Surgical Prep Done JOHNSON RN, MARK ANTHONY By Skin Prep Nursing Care Plan Outcome: The Yes patient is free from signs and symptoms of chemical injury. Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 14:45:19 Counts Initial SD HA Entry 1 Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 55 of 84 57 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: DE9876543210 Admit Date: 2/8/2023

Surgical Documents

Procedure: MARK Type: Arthroplasty Total Items Included in the Initial Count: Hipl Right, Hipl Sponge Count, Small Miscellaneous Item Count, Sharps/Needles Count Counts By: JOHNSON RN, MARK ANTHONY, THOMPSON, OLIVIA Last Modified By: JOHNSON RN, MARK ANTHONY DATE 02/08/23 14:45:43

Surgical Procedures SD HA

Entry 1 Procedure Information Pick List: Arthroplasty Total Hip Actual Procedure Performed: Right total hip arthroplasty Primary Surgeon: FINCH MD, ALISTAIR Stop: 02/08/23 15:40:00 Specialty: SN Orthopedics Primary Closure: Yes Last Modified By: JOHNSON RN, MARK ANTHONY DATE 02/08/23 15:44:42 Modifiers: Right, Hip Primary Procedure: Yes Start: 02/08/23 14:37:00 Anesthesia Type: Spinal Wound Class: Clean

Cautery SD HA

Entry 1 ESU Identification: UNIT ELECTROSURGICAL ESU Type: VALLEYLAB OH HA Clinical Engineering/Biomed Number: 027116 ESU Settings Cut Setting: 90 ESU Grounding Pad Grounding Pad Site: Back Post-op Ground site assessment: No abnormality noted Coag Setting: 90 Pre-op Ground site assessment: No abnormality noted Cautery Nursing Care Plan Outcome: Patient is free from signs and symptoms of electrical injury. Yes Last Modified By: JOHNSON RN, MARK ANTHONY DATE 02/08/23 14:46:10

Equipment SD HA

Entry 1 Equipment Equipment Type: MACHINE SEQUENTIAL COMPRESSION OH Equipment Setting: 40 mmhg Clincial Engineering Number/Biomed Number: 9152 Equipment Nursing Care Plan Diagnosis: Risk of physical injury. Outcome: The patient is free Yes Entry 2 Equipment Equipment Type: MACHINE SUCTION NEPTUNE OH HA Equipment Setting: High Clincial Engineering Number/Biomed Number: 041196 Equipment Nursing Care Plan Outcome: The patient is free Yes Report Request ID: 987654321 Requester: BENNETT, CLARA Printed On: 3/7/2023 14:17 EST Page 56 of 84 Back to top 58 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: DE9876543210 Admit Date: 2/8/2023

Surgical Documents

from signs and symptoms of physical injury. Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 14:47:57

Implant/ Explant Log SD HA	**Entry 1**	**Entry 2**	**Entry 3**	**Entry 4**	**Entry 5**
	Entry 1	Entry 2	Entry 3	Entry 4	Entry 5
Implant	Implant	Implant	Implant	Implant	Implant
Identification	ZIMMER, INC., BIOMET	ZIMMER, INC.	SCREW SELF TAF	STEM FEMORAL 117X9 MM	HEAD FEMORAL +3.5MM
Implant/ Explant Description	ACETABULAR SHELL 54 MM REF. 110010245	CROSSLINKED POLYETHYLENE LINER 36 MM REF 20103606	006 25006 535	43MM 00771100900	12/14 36MM 00877503603
6.5X35MM					
Disposition of Explant					
Lot Number	65514794	656 27100	J7389436	65618266	3137140
Manufacturer	ZIMMER, INC.	ZIMMER, INC.	ZIMMER INC	ZIMMER INC	IZ
Implant Expiration Date	11/03/32	10/23/27	11/23/32		
Catalog #	110010245	201036 06	006 25006 539		
Serial Number	NA	NA	NA		
Size	54 MM F	36 MM	6.5 X 35 MM		
Tissue prepared according to Vendor Card Completed	No	No	No		

Implant/ Explant Log SD HA	**Entry 1**	**Entry 2**	**Entry 3**	**Entry 4**	**Entry 5**
Tissue Prepared By:					
Tissue Prepared Date/Time					
Prep Solution:					
Solution Lot Number:					
Solution Expiration Date:					
Usage Data					
Modifiers					
Implant/ Explant Site	Right	Right	Right		
Quantity	Hip 1	Hip 1	Hip 7		
Implant/ Explant Nursing Care Plan Diagnosis: Risk of injury. Outcome: Patient is free from signs and symptoms of injury due to extraneous objects.	Yes	Yes	Yes		
Last Modified By:	JOHNSON RN, MARK ANTHONY	JOHNSON RN, MARK ANTHONY	JOHNSON LCSW, SARAH		

Implant/ Explant Log SD HA	Entry 1	Entry 2	Entry 3	Entry 4	Entry 5
	02/08/23 14:59:27	02/06/23 15:00:44	02/09/23 12:25:02		

Implant Expiration Date	10/30/32	12/09/32
Catalog #	00771100900	008775036 08
Serial Number	NA	NA
Size	9	+3. E
Tissue prepared according to: Vendor Card Completed	No	No
Tissue Prepared By:		
Tissue Prepared Date/Time		
Prep Solution:		
Solution Lot Number:		
Solution Expiration Date		
Usage Data Modifiers	Right	Right
Implant/Explant Site	Hip	Hip
Quantity	1	1
Implant/Explant Nursing Care Plan Diagnosis: Risk of injury.		
Outcome: Patient is free from signs and symptoms of injury due to extraneous objects.	Yes	Yes
Last Modified By:	JOHNSON RN, MARK ANTHONY 02/08/23 15:06:25	JOHNSON RN, MARK ANTHONY 02/08/23 15:07:45

Catheter/Tubes/Drains SD HA

Entry 1		Quantity	1
Device Type		Inserted By	

	TRAY CATH FOLEY 16 2 WAY 16 FR SML W/STATLOCK		JOHNSON RN, MARK 02/08/23 14:15:00
Location/Insertion	Bladder	Urinary Catheter Insertion Date/Time	
Site	Insert	Urinary Catheter Balloon	10 mL sterile water
Urinary Catheter Activity Type	Indwelling	Urinary Catheter Drainage System	Dependent drainage
Urinary Catheter Type	Stabilization Device	Urine Color	Yellow
Urinary Catheter Secured	None		
Unexpected Response	Clear		
Urine Description			
TD Nursing Care Plan Outcome: The patient is free from signs and symptoms of infection	Yes		
Last Modified By:	JOHNSON RN, MARK ANTHONY 02/08/23 14:49:23	Last Modified By	JOHNSON RN, MARK ANTHONY 02/08/23 15:07:45

Counts Subsequent SD HA

Sequence Closing Count

Entry 1

Procedure Arthroplasty Total Hip Right, Hip1

 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: DE9876543210 Surgical Documents By: THOMPSON, OLIVIA, Sponges Count JOHNSON RN, MARK Correct: Yes ANTHONY Small Miscellaneous Yes Sharps/Needles Item Count Correct: Count Correct: Yes Instruments Count n/a Provider Notified Correct: Closing Counts Yes Correct: Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 15:14:38 Counts Final SD HA Final Count Time Entry 1 Counts By: THOMPSON, OLIVIA, 02/08/23 15:39:00 JOHNSON RN, MARK

ANTHONY Procedure Arthroplasty Total Sponges Count Yes Hip| Right, Hip| Correct: Small Miscellaneous Yes Sharps/Needles Yes Item Count Correct: Counts Correct: Instruments Counts n/a Provider Notified Yes Correct: Closing Counts Yea Counts Final - Yes Correct: Nursing Care Plan Outcome: Patient is free from signs and symptoms of injury caused by extraneous object(s). Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 15:44:29 Dressing/Packing/Cast/Support SD HA Entry 1 Dressing Dressing Items Abdominal Pad, Adaptic, Site Right, Hip Gauze Sponge, Staples, Tegaderm Packing Support Support Items Hip Abduction Pillow Site Bilateral, Leg Cast Last Modified By: JOHNSON RN, MARK ANTHONY 02/08/23 14:50:42 Departure from OR SD HA Entry 1 Via Bed Post-op Destination PACU/Recovery Room Report Given To N/A OR Team Debriefing Yes Completed (Count status, Specimen verification, Procedure and Post-op diag verification, Wound Classification, Post-op considerations Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 59 of 84 61 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 03/10/2024 - 03/20/2024

Patient Name: MILLER, ARTHUR Admit Date: 3/9/2024

FIN: 987654321098

Surgical Documents

Departure From OR - Nursing Care Plan	**discussed, and Issues/Concerns addressed)**
Outcome: The patient is free from signs and symptoms of injury. Last Modified By: JOHNSON RN, MARK ANTHONY 03/09/24 15:00:00	

Case Comments

Allergies identified in patient's electronic medical record at time of printing on 03/10/24 Entry 1

Substance:	**No Known Allergies**
Reaction Type:	Allergy

Last Modified By: FORD RN, ARTHUR 02/04/09 01:00:00

Finalized By: JOHNSON LCSW, SARAH

Document Signatures Signed By: JOHNSON RN, MARK ANTHONY 03/09/24 15:45 JOHNSON LCSW, SARAH 03/10/24 13:00

Unfinalized History

Date/Time	Username	Reason for Unfinalizing	Freetext Reason for Unfinalizing
03/10/24 12:45	USERID1	Modify Pick List	

DOCUMENT NAME:	**PACU Nursing Record**
SERVICE DATE/TIME:	3/9/2024 16:00 EST
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	BARTON RN,CLARA (3/9/2024 19:00 EST)
SIGN INFORMATION:	BARTON RN,CLARA (3/9/2024 19:00 EST)
AUTHENTICATED BY:	

PACU I Nursing Record SD HA PACU I Nursing Record SD HA Summary

Primary Physician:	**FINCH, ALISTAIR MD**
Case Number:	CMCG-2024-987
Finalized Date/Time:	03/09/24 19:00:00
Pt. Name:	MILLER, ARTHUR
D. O. B. /Sex:	05/21/1965 Male
Med Rec #:	123456789
Physician:	FINCH, ALISTAIR MD
Financial #:	987654321098
Pt. Type:	C

Surgical Documents

Room/Bed: 2613/01 Admit/Disch: 02/08/23 04:00:00 - Institution: Case Times PACU I SD HA In Phase I Entry 1 Phase I Criteria Met 02/08/23 18:52:00 Phase I Discharge 02/08/23 18:52:00 Last Modified By: BARTON RN, CLARA 02/08/23 18:52:24 Finalized By: BARTON RN, CLARA Document Signatures

Signed By: BARTON RN, CLARA 02/08/23 18:52

DOCUMENT NAME: Operative Report SERVICE DATE/TIME: 2/9/2023 08:53 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: FINCH MD, ALISTAIR (2/9/2023 08:54 EST) SIGN INFORMATION: FINCH MD, ALISTAIR (2/9/2023 08:54 EST) AUTHENTICATED BY: FINCH MD, ALISTAIR (2/9/2023 08:54 EST) Right Total Hip Arthroplasty "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician" Patient: MILLER, ARTHUR MRN: C-987654321 FIN: 987654321098 Age: 57 years Sex: Male DOB: 05/21/1965 Associated Diagnoses: None Author: FINCH MD, ALISTAIR Document Created Document Creation: 02/09/23 08:53 Date of Service Date of Service: 02/08/2023. Procedure Procedure Case Number: HASD-2023-155 Surgery Start: 02/08/2023 14:37 Pre-Op Diagnosis: Right Hip Osteoarthritis. Post-Op Diagnosis: Right Hip Osteoarthritis. Procedure Performed: Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 61 of 84 Back to top 63 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admitting Date: 2/8/2023 FIN: 987654321098

Surgical Documents

Right total hip arthroplasty Case Attendees: FINCH MD, ALISTAIR in the role of Surgeon - Primary THORNE MD, ELIAS in the role of Anesthesiologist O'CONNELL MD, LIAM in the role of Anesthesia Resident SHARMA NP, ANYA S in the role of Physician Assistant 1st Assist THOMPSON, OLIVIA in the role of Scrub 1 JOHNSON RN, MARK ANTHONY in the role of Circulator 1 Anesthesia Type: Spinal 02/08/2023 14:45 Confirmed Patient, procedure, side, and site are correct. Estimated Blood Loss 150 ml. Specimen obtained None. Intra-Operative Details 1. Zimmer Biomet G7 Trilogy Poly - 36 2. Zimmer Biomet G7 Shell with Cluster Holes - 55 3. Zimmer M/L Taper Femoral Stem 12/14 Size 9 Standard 4. Zimmer Femoral

Head 36 + 3.5 Ceramic 5. Zimmer Bone Screw 35mm NO QUALIFIED RESIDENTS AVAILABLE FOR THE CASE This patient failed conservative management for pain in the hip. All risks, benefits, details and treatment alternatives were discussed with the patient, including the risk of post operative pain, infection, scarring, the possible need for revisions, blood loss, and even the chance of death. After obtaining informed consent for a total hip arthroplasty, the patient's extremity was marked and they were brought back to the surgical theater. The anesthetic was administered and the patient was placed in the decubitus position with the operative side up. A standard "time-out" procedure was performed. A standard posterolateral incision was performed down through the skin and subcutaneous tissues down to the level of the fascia. The fascia was breached and a Charnley retractor was placed deep, taking care to protect the sciatic nerve. With slight internal rotation the bursa was incised of the femur exposing the medius. The medius was retracted. Access to the short external rotators was achieved. They were exposed and tagged with a #5 Ethibond suture. Report Request ID: 987654321 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 62 of 84 Back to top 64 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 2/8/2023

Surgical Documents

They were subsequently removed off the posterior femur. The minimus was elevated and a posterior capsular flap was created and also tagged. The quadratus was taken down and the hip dislocated. A 10mm neck cut was performed. The femur was retracted over the anterior acetabulum. Retractors were placed around the actetabulum. After exposing the medial wall, and identifying the tear drop, reaming commenced with 1mm below the implanted size and proceeded to a mm above. The final implant was impacted into place with excellent press fit. One bone screw was utilized to augment fixation. The poly liner was placed. Attention was then turned to the femur. After entering the femoral canal with a drill and box chisel, we lateralized then broaced up to the appropriate femoral stem. A trial reduction was done with a standard neck and head. Good stability and restoration of leg length was achieved. The broach was removed and the final implant was impacted into place. The head was used. The short external rotators and capusle were repaired through drill holes in the trochanter. The quadratus and bursa were also reattached using #1 Vicryl. The subcutaneous tissues were closed using 2-0 Vicryl and skin was closed using staples. Sponge and needle counts were correct...

Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 63 of 84 Back to top From Community Wellness Center 11111111111 Auth (Verified) 987654321098 1/27/2023 07:57:20 PST Page 2 of 2 2023-01-23 15:29 FIN: 987654321098 UHC ORTHO 5559990000 >> 5559990001 P 1/1 2 MILLER, ARTHUR 3 05/21/1965 M 0 HA 2BNS/2613/01 DOS: 02/08/23 04:00 5 POP-VANCE MD ELIAS 5 ATTN: FINCH MD, ALISTAIR 0 PTRD: 98765432 3 CPMC 0 5 Leading. Orthopaedic. Care. P 0 Prairie General Hospital 0 0 0 0 0 Primary Care Doctor 8 Pre-operative Assessment form for Surgical Clearance 6 5 Prior to having surgery the patient will need medical clearance. Once you have cleared the patient please fax this form and requested documentation to FAX # 402-555-5678 Please call Clara @ 402-555-8000 for any further questions. Thank you. PLEASE COMPLETE 30 DAYS PRIOR TO SURGERY. Patient Name: Arthur Miller DOB: 05 / 21 / 1965 Procedure: Right total Hip Replacement Surgeon: Dr. Alistair Finch Date of Surgery: 1 / 30 / 23 Specialty Clearance(s) Requested: At Your Discretion

BLOOD THINNER STOP DATE PRIOR TO SURGERY Noma (None)

CARDIAC	+	-	Comments	PULMONARY	+	-	Comments
CHF	✓			Asthma/COPD	✓		
ICD/Pacemaker (company)	✓			Restrictive Lung Disease	✓		
HTN	✓			OTHER			
PVD	✓						
Syncope	✓						
Heart Disease	✓						
Dysrhythmia	✓						

Please send the Following test Results:

- Labs: CMP, CBC, PT W/INR, PTT, A1C, Electrolytes, UA WC&S
- Chest X-ray
- EKG w/interpretation
- Medication List

IS THE PATIENT CLEARED FOR SURGERY? YES ✓ NO Physician Name: Dr. Emily Carter, MD Date: 1-27-23 Signature: Phone: 217-555-5678 66 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 -

02/09/2023 Auth (Verified) From Community Wellness Center 987654321098 Officer Facility: EMILY CARTER PEDIATRICS PLLC 10000000000 2 Physician: 1/27/2023 07:57:20 PST 3 PatName(lastfirst): Miller, Arthur 8:55:13 AM, Jan 20, 2023 Page 1 of 2 0 ID: 999888777 HR(bpm): 87 (lead V5) (IHR 87) 5 Age: 58, Sex: M, Ht, Wt, DOB: 05/21/1965 RR(ms): 689 5 Nurse/Tech:, Room: P dur (ms): 93 0 Medications: PR Int (ms): 93 3 Meds (cont): QRS dur (ms): 83 0 Blood pressure: na P/R/T axis: 64/66/59, QT:331. 5 Proto: Bruce QTcb:401.QTcf:376.QTch:378.QTefr:331. P Speed: 0.0mph,Grade: 0.0% Referring Physician: N/A 0 Confirmed by: 0 10mm/mV, 0.05-150Hz, 40HzLPF, 25mm/sec- DIAG: ABN,Brady,ALVA,Short P 0 0 0 0 0 8 6 5 I: aVR: V1: V4: II: aVL: V2: V5: III: aVF: V3: V6: Rhythm II: Community Support Connect (c)2024 (9.01_240315_DESKTOP-XYZ123_W11_64) (8,88) A physician should overread the results Real 1 Poor Quality Back to top

67 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

[Back to top](#) Patient Name: MILLER, ARTHUR Patient: MILLER, ARTHUR MRN: M-987654321 Admit Date: 2/8/2023 FIN: 987654321098 Age: 58 years Sex: Male DOB: 05/21/1965 FIN: 987654321098 Associated Diagnoses: Osteoarthritis of right hip Author: SHARMA NP, ANYA S

Surgical Documents

DOCUMENT NAME: MLP Post Op Note SERVICE DATE/TIME: 2/8/2023 15:48 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: SHARMA NP, ANYA S (2/8/2023 15:50 EST) SIGN INFORMATION: FINCH MD, ALISTAIR (3/7/2023 08:32 EST); SHARMA NP, ANYA S (2/8/2023 15:50 EST) AUTHENTICATED BY: SHARMA NP, ANYA S (2/8/2023 15:50 EST) City General MLP Immediate Post Operative "If completed by a medical trainee this document will be reviewed and amended by a supervisor. This document should not be used for physician billing if completed by a MLP unless employed by/or under a shared services agreement with that physician"

Document Created

Document Creation: 02/08/23 15:48 .

Date of Service

Date of Service: 02/08/2023.

Procedure

Procedure Case Number: AHBC-2023-789 Surgery Start: 02/08/2023 14:37 Pre-Op Diagnosis: Right Hip Osteoarthritis. Post-Op Diagnosis: Right Hip Osteoarthritis. Procedure Performed: Right total hip arthroplasty Case Attendees: FINCH MD, ALISTAIR in the role of Surgeon - Primary THORNE MD, ELIAS in the role of Anesthesiologist O'CONNELL MD, LIAM in the role of Anesthesia Resident SHARMA NP, ANYA S in the role of Physician Assistant 1st Assist THOMPSON, OLIVIA in the role of Scrub 1 JOHNSON RN, MARK ANTHONY in the role of Circulator 1 Anesthesia Type: Spinal 02/08/2023 14:45

Date of Surgery

02/08/2023. Confirmed Report Request ID: 987654321 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 67 of 84 Back to top 69 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023

FIN: 9876543210

Surgical Documents

Patient, procedure, side, and site are correct. Performed by FINCH MD, ALISTAIR Surgeon. Assistant SHARMA NP, ANYA S. Physician assistant. 1st assist. I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier. Pre-Operative diagnosis Osteoarthritis of right hip (ICD10-CM M16.11, Admitting, Medical). Post-Operative diagnosis Osteoarthritis of right hip (ICD10-CM M16.11, Admitting, Medical). Procedure performed Right Total Hip Arthroplasty. Estimated Blood Loss 200 ml. Intravenous Fluids 800 ml crystalloid. Urine output 50 ml. Specimen obtained None. Anesthesia Regional: Spinal.

Conscious sedation. Complications None apparent. Peripheral catheter Urinary catheter Inserted 02/08/2023. Indication pain and xray findings. Informed consent Signed by patient. Preparation and technique X-ray obtained prior to procedure. Medication prior to procedure. Monitoring during procedure: blood pressure monitoring, cardiac monitor, pulse ox. Sterile preparation of site: with 2% chlorhexidine gluconate. Position: lateral. Findings osteoarthritis. Condition Good. Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT,CLARA Page 68 of 84 70 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 9876543210 Surgical Documents Procedure tolerated Well. Plan Post-Operative: Disposition PACU, and patient floor. Plan Admit to 2 Brush for postoperative care including: Pain management DVT Prophy PT/OT-WBAT Hip Precautions CMS Consult- DC Planning- Home vs. SAR. Professional Services Creator Information: SHARMA NP, ANYA S, Phone Number: 555-123-4567, Nurse Practitioner. Service ortho. MLP Role Acting under the supervision of the Attending Physician. Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 69 of 84 Back to top 71 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 04/15/2024 - 04/28/2024 Patient Name: MILLER, ARTHUR Admit Date: 4/15/2024 FIN: DE9876543210 Therapy Services DOCUMENT NAME: PT Initial Evaluation Acute Care SERVICE DATE/TIME: 4/16/2024 10:00 EST RESULT STATUS: Modified PERFORM INFORMATION: THORNE, ELIAS (4/16/2024 13:44 EST) SIGN INFORMATION: THORNE, ELIAS (4/16/2024 13:53 EST); THORNE, ELIAS (4/16/2024 13:44 EST) AUTHENTICATED BY: THORNE, ELIAS (4/16/2024 13:53 EST); THORNE, ELIAS (4/16/2024 13:44 EST) PT Initial Evaluation Acute Care Entered On: 4/16/2024 13:53 EST Performed On: 4/16/2024 10:00 EST by THORNE, ELIAS General Info Reason for Referral to Physical Therapy : Other: S/P Rt THA. Sensory Deficits : Other: Reading glasses Therapist Pager Number : (313) 555-9876 Precautions to Rehabilitation Treatment : Fall, Hip precautions, Hip replacement, Twisting THORNE, ELIAS - 4/16/2024 13:44 EST Past Medical & Surgical History : AVN, OA Rt hip. THORNE, ELIAS - 4/16/2024 13:53 EST {[AVN, OA Rt hip.] previously charted by THORNE, ELIAS at 4/16/2024 13:44 EST} Pain Symptoms : Yes Orientation Rehab : Oriented x 4 Safety/Judgment : Intact Basic Command Following : Intact Problem Solving : Intact THORNE, ELIAS - 4/16/2024 13:44 EST Weight Bearing Response Grid

RLE Weight bearing as tolerated

THORNE, ELIAS - 4/16/2024 13:44 EST

Primary Pain Primary Pain Location : Hip Primary Pain Laterality : Right Adult Pain Scale : VAS Pain Score (Rest) : 2 Pain Score (Activity) : 3 THORNE, ELIAS -

4/16/2024 13:44 EST Home Environment Home Environment Comment : Pt reports he plans to stay w/hie brother for addtional assistance. Apt setup 2nd floor w/4 STE. THORNE, ELIAS - 4/16/2024 13:44 EST COVRP Report Request ID: 987654321 Printed On: 05/01/2024 14:17 EST Requester: BENNETT, CLARA Page 75 of 99 Back to top 72 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Therapy Services

COVRP Ambulation at Home : Independent Ambulation to toilet : Independent Bathing : Independent Bed Mobility : Independent Community Ambulation : Independent Dressing, Upper Extremity: Independent Dressing, Lower Extremity: Independent Eating : Independent Grooming : Independent Stairs : Independent Toileting: clothing : Independent Toileting: hygiene : Independent Transfers: Bed-chair : Independent Transfers: Car : Independent Transfers: Floor : Independent Transfers: Toilet : Independent Living Situation : Home with family THORNE, ELIAS - 2/9/2023 13:44 EST Home Equipment : None THORNE, ELIAS - 2/9/2023 13:44 EST Musculoskeletal Right Lower Extremity : Limited THORNE, ELIAS - 2/9/2023 13:44 EST Right Lower Extremity Strength2 : Limited LE Strength Detailed : Yes LE Strength THORNE, ELIAS - 2/9/2023 13:44 EST Extremity Strength Comment : Rt hip strength 3-/5 Balance THORNE, ELIAS - 2/9/2023 13:44 EST Balance - static sitting, supported : Normal Balance - dynamic sitting, supported : Limited Balance - static standing, supported : Limited Balance - dynamic standing, supported : Limited Balance Comment : Stand s/d fair w/walker Functional Mobility/Therapeutic Activity Therapeutic Activity Performed : Bed mobs roll and sup <> sit bed side SBA sit <> stand and transfers SBA w/walker Thera session: Sit <> stand and transfer act tr w/std walker use. Safety issues - hip precautions reviewed w/pt. Proper walker placement and stepping technique taught (Comment: and practiced. Dispo needs and recommendations discussed w/pt. Self thera exs explained to the pt. 2-3 reps each practiced for proper execution. 1. ankle pumps, 2. knee flex/ext, 3. leg slides. Recommend cont self 10-15 reps/hour. Modify reps and sets per tolerance. Pt verbalized understanding to all exs and executed practice reps well. [THORNE, ELIAS - 2/9/2023 13:44 EST]) THORNE, ELIAS - 2/9/2023 13:44 EST Gait Gait Grid Trial : 1 Report Request ID: 987654321 Printed On: 4/1/2024 10:30 MST Requester: BENNETT, CLARA Page 71 of 84 73 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Therapy Services

Assist Level:	**5: Supervision/stand-by**
Device:	Walker, standard
Distance:	220 ft
Wt-Bearing Maintained:	Yes
Surface:	Level tile
	THORNE PT, ELIAS - 2/9/2023 13:44 EST

Stair Ambulation GRID

Trial:	**1**
Number of Steps:	5
Railing:	Bilateral
Assist Level:	5: Supervision/stand-by
Device:	None
Wt-Bearing Maintained:	Yes
	THORNE PT, ELIAS - 2/9/2023 13:44 EST

Assessment/Problem List

PT Problem List: Ambulation deficits, Balance deficits, Decreased activity tolerance, Decreased functional mobility, Gait deficits, Strength deficits, Stair management deficits, Transfer deficits PT Assessment Comment: S/P Rt THA. NAD. Slow movements. Periodic rests provided throughout session for safety and stability. THORNE PT, ELIAS - 2/9/2023 13:44 EST

Plan

PT Frequency: Other: BID or as needed. PT Duration: LOS PT Anticipated Treatments: Balance training, Bed mobility training, DME education, Gait training, Neuromuscular reeducation, Patient/caregiver education, Safety education, Stair training, Therapeutic exercises, Transfer training THORNE PT, ELIAS - 2/9/2023 13:44 EST PT Plan/Goals Established w Pt/Caregiver: Yes

Goals

PT Goals - Adult Grid

Goal Topics:	**Other: Bed mobs mod I, Gait 300 feet mod I w/std walker, stairs 5 STE mod I**

Therapy Services

Goal Status	
Ongoing	transfers mod I w/std walker, balance stand s/d good w/std walker, strength Rt hip 4/5. THORNE PT, ELIAS - 2/9/2023 13:44 EST

PT Goals Reviewed : Goals established THORNE PT, ELIAS - 2/9/2023 13:44 EST Education Education History Results : Procedure Type: Right THA Topic: Discharge planning, Infection prevention, Peri-Op Plan of Care: Infection, Injury, Anxiety, Body Image Individuals Taught: Patient, Friend Barriers to Learning: None Teaching Method: Explanation, Verbal Teaching Evaluation: Follow-Up Needed, Teaching Ongoing Comment: pt and friend verbalized understanding, no further questions Performed by: BARTON RN, CLARA - 02/08/23 16:32:00 Procedure Type: right THA Topic: Anesthesia/Sedation, Anxiety Reduction Techniques, Infection prevention, Infection Prevention: Surgical Site Infection Prior to Proce, Medication instructions, Need for overnight adult supervision, Pain management, Peri-Op Plan of Care: Infection, Inju... Individuals Taught: Patient Barriers to Learning: None Teaching Method: Verbal Teaching Evaluation: Met Comment: has no further questions Performed by: PETROVA RN, ANASTASIA - 02/08/23 12:52:00 Topic: Infection prevention, Leave valuables at home, Medication instructions, NPO instructions, Preprocedure Prep, Preprocedure tests/labs, Surgery date/time/location reviewed Individuals Taught: Patient Barriers to Learning: None Teaching Method: Explanation, Teach Back, Verbal, Written/Handouts Teaching Evaluation: Met Comment: Preop instruction given and Reviewed --02/02/2023 Alice Smith PCA. Performed by: JENKINS RN, SARAH - 02/02/23 10:04:00 Procedure Type: Preop Topic: Family instructions, Infection prevention, Leave valuables at home, Medication instructions, Pain management, Preprocedure diet, Spoke with patient/family about concerns, Surgery date/time/location reviewed Individuals Taught: Patient Barriers to Learning: None Teaching Method: Explanation, Teach Back, Verbal, Written/Handouts Teaching Evaluation: Met Report Request ID: 987654321 Printed On: 5/15/2024 14:17 EST Requester: BENNETT, CLARA Page 73 of 84 Back to top 75 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Therapy Services

Teaching Method: Printed materials, Teach Back, Telephone Teaching Evaluation: Met Comment: Willow Creek Medical Center Preop # givenaarrival time 1000. talk to patient EB Performed by: Jenkins RN, Sarah - 01/18/23 07:58:00 THORNE, ELIAS - 2/9/2023 13:44 EST PT Education Row

	Topics	
	Other: Safety- hip precautions, Fall precautions - call for assist for all OOB acts, proper use of std walker and stepping technique, Dispo recommendations, self exs technique	
Individuals Taught		Patient
Barriers to Learning		None
Teaching Method		Explanation, Practice, Verbal
Learning Response / Teaching Evaluation		Met
		THORNE, ELIAS - 2/9/2023 13:44 EST

Discharge Recommendations - PT Discharge To, Anticipated - PT : Home with Home Health - Followed by OP Therapy Discharge - Dx, PT : Ortho Home Equipment, Anticipated - PT : Walker Walker Specifics - PT : Standard folding Prof Skill'd Services, Anticipated - PT : Physical Therapy THORNE, ELIAS - 2/9/2023 13:44 EST PT Charges PT Eval Complexity : Moderate Complexity PT Evaluation Time : 25 Minute(s) Total Treatment Time - PT : 32 Minute(s) Therapeutic Activity Minutes : 13 Minute(s) Therapeutic Activity Units : 1 Units Therapeutic Exercise Charge : Yes Gait Training Minutes : 19 Minute(s) Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 74 of 84 Back to top 76 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 2/8/2023

Therapy Services

Gait Training Units : 1 Units Gait Training Charges : Yes THORNE PT, ELIAS - 2/9/2023 13:44 EST DOCUMENT NAME: OT Initial Evaluation Acute Care SERVICE DATE/TIME: 2/9/2023 11:15 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: Miller,Robert (2/9/2023 14:57 EST) SIGN INFORMATION: Miller,Robert (2/9/2023 14:57 EST) AUTHENTICATED BY: Miller,Robert (2/9/2023 14:57 EST) OT Initial Evaluation Acute Care Entered On: 2/9/2023 15:07 EST Performed On: 2/9/2023 11:15 EST by Miller, Robert General Info Reason for Referral to OT : Decreased balance, Patient/Caregiver education, Other: OT Eval and Tx Sensory Deficits : Other: Reading glasses Therapist Pager Number : 555-0123 2613-1 OT Personnel Documenting : OT Past Medical & Surgical History : PMH: Avascular necrosis of R hip Pain Symptoms : Yes Orientation : Oriented x 4 Safety/Judgment : Intact Basic Command Following : Intact Problem Solving : Intact Weight Bearing Response Grid

RLE Weight bearing as

tolerated

Miller, Robert -

2/9/2023 14:57

EST

Miller, Robert - 2/9/2023 14:57 EST OT General Info Comment : 51 yo M who has had chronic right hip pain secondary to o/a. s/p R THA on 2/8/23 Miller, Robert - 2/9/2023 14:57 EST Primary Pain Primary Pain Location : Hip Pain Score (Activity) : 2 Primary Pain Time Pattern : Acute Primary Pain Quality : Aching, Incisional Primary Pain Interventions : Medications, RN notified Primary Pain Aggravating Factors : None Primary Pain Alleviating Factors : Repositioning Associated Symptoms : None Report Request ID: 149234930 Requester: BENNETT,CLARA Printed On: 3/7/2023 14:17 EST Page 75 of 84 77 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Therapy Services

Home Environment Miller, Robert - 2/9/2023 14:57 EST Home Environment Comment : Pt reports that he will be living with brother who livves in apartment with elevator and 5 STE to enter building. prior to admission pt states he was IND

with I/ADLs functional mob and working with no AD or DME needs. Lives In : Apartment Lives With : Sibling(s) COVRP Miller, Robert - 2/9/2023 14:57 EST

Outside Stairs

Number of Stairs: 5

Miller, Robert - 2/9/2023 14:57 EST

Elevator : Yes Patient's Responsibilities : Community mobility, Health and wellness, Laundry, Leisure/Play/Hobbies, Meal preparation, Personal ADL, Work Miller, Robert - 2/9/2023 14:57 EST COVRP Ambulation at Home : Independent Ambulation to toilet : Independent Bathing : Independent Bed Mobility : Independent Community Ambulation : Independent Dressing, Upper Extremity : Independent Dressing, Lower Extremity : Independent Eating : Independent Grooming : Independent Stairs : Independent Toileting: clothing : Independent Toileting: hygiene : Independent Transfers: Bed-chair : Independent Transfers: Car : Independent Transfers: Floor : Independent Transfers: Toilet : Independent Miller, Robert - 2/9/2023 14:57 EST Living Situation : Home with family Home Equipment : None Professional Skilled Services : None Miller, Robert - 2/9/2023 14:57 EST Musculoskeletal Hand Dominance : Right Left Upper Extremity : WNL Right Upper Extremity : WNL Left Upper Extremity : WNL Right Upper Extremity : WNL Miller, Robert - 2/9/2023 14:57 EST Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 76 of 84 78 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Therapy Services

Balance Balance - static sitting, supported : Normal Balance - dynamic sitting, supported : Normal Balance - static standing, supported : Normal Balance - dynamic standing, supported : Limited Neuro Exam Muscle Tone - Detailed : Normal Sensation Within Normal Limits : Yes Coordination : Normal Miller, Robert - 2/9/2023 14:57 EST ADL Assist Level Grid

	Eating	**Grooming**	**Bathing - upper extremity**	**Bathing - lower extremity**
Assist Level	7: Independent	5: Supervision/ stand -by	7: Independent	5: Supervision/ stand -by
	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST

	Dressing - Upper Extremity	Dressing - Lower Extremity	Toileting - Clothing	Toileting - hygiene
Assist Level	7: Independent	5: Supervision/ stand -by	5: Supervision/ stand -by	7: Independent
	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST

Miller, Robert - 2/9/2023 14:57 EST Functional Mobility Functional Mobility Goals Grid

	Bed mobility - sit to supine	Bed mobility - supine to sit	Sit to stand	Stand to sit
Assist Level	Supervision/ stand -by	Supervision/ stand -by	Supervision/ stand -by	Supervision/ stand -by
Device/ Equipment				Walker, standard
	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST	Miller, Robert - 2/9/2023 14:57 EST

Assessment OT Problem List : Balance deficits, Range of motion deficits OT Assessment Comment : Pt tolerates evaluation well and demo good use of AE during LB dressing. Miller, Robert - 2/9/2023 14:57 EST Plan OT Frequency : 3-5 times per week Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 77 of 84 Back to top 79 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 2/8/2023

Therapy Services

OT Duration : LOS OT Anticipated Treatments : Activity of daily living training, Balance training, Mobility training, Patient/Caregiver education, Safety education, Therapeutic activities, Therapeutic exercises OT Tx Plan/Goals Established w Patient : Yes Miller, Robert - 2/9/2023 14:57 EST Goals OT Goals - Adult Grid Goal Topics: Dressing: lower body Toileting Transfers: bed/chair Transfers: toilet Long Term Goals: 6: Modified 6: Modified 6: Modified 6: Modified independent independent independent independent Miller, Robert - Miller, Robert - Miller, Robert - Miller, Robert - 2/9/2023 14:57 EST 2/9/2023 14:57 EST 2/9/2023 14:57 EST 2/9/2023 14:57 EST OT Goals Reviewed : Goals established Education Education

History Results : Topic: Discharge teaching Individuals Taught: Patient Barriers to Learning: None Teaching Method: Ask Me 3, Explanation, Printed materials, Teach Back Teaching Evaluation: Met Comment: Educated patient to attend follow up appointments. Educated about discharge prescriptions. Report any fever equal or greater to 100.4, or any foul drainage from incision site. Provided supplies for home dressing changes. Pt verbalized understanding. Performed by: BENSON RN, CLARA - 02/09/23 14:33:00 Miller, Robert - 2/9/2023 14:57 EST Topic: Other: Safety-hip precautions, Fall precautions - call for assist for all OOB acts, proper use of std walker and stepping technique, Dispo recommendations, self exs technique Individuals Taught: Patient Barriers to Learning: None Teaching Method: Explanation, Practice, Verbal Teaching Evaluation: Met Performed by: THORNE PT, ELIAS - 02/09/23 13:44:00 Procedure Type: Right THA Topic: Discharge planning, Infection prevention, Peri-Op Plan of Care: Infection, Injury, Anxiety, Body Image Individuals Taught: Patient, Friend Barriers to Learning: None Teaching Method: Explanation, Verbal Teaching Evaluation: Follow-Up Needed, Teaching Ongoing Comment: pt and friend verbalized understanding, no further questions Performed by: BARTON RN, CLARA - 02/08/23 16:32:00 Procedure Type: right THA Topic: Anesthesia/Sedation, Anxiety Reduction Techniques, Infection prevention, Infection Prevention: Surgical Site Infection Prior to Proce, Medication instructions, Need for overnight adult supervision, Pain management, Peri-Op Plan of Care: Infection, Inju... Individuals Taught: Patient Report Request ID: 555-123-789 Printed On: 4/15/2024 09:30 CST Requester: BENNETT, CLARA Page 78 of 84 Back to top 80 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Therapy Services

Barriers to Learning: None Teaching Method: Verbal Teaching Evaluation: Met Comment: has no further questions Performed by: PETROVA RN, ANASTASIA - 02/08/23 12:52:00 Topic: Infection prevention, Leave valuables at home, Medication instructions, NPO instructions, Preprocedure Prep, Preprocedure tests/labs, Surgery date/time/location reviewed Individuals Taught: Patient Barriers to Learning: None Teaching Method: Explanation, Teach Back, Verbal, Written/Handouts Teaching Evaluation: Met Comment: Preop instruction given and Reviewed -02/02/2023 Alice Smith PCA. Performed by: JENKINS RN, SARAH - 02/02/23 10:04:00 Procedure Type: Preop Topic: Family instructions, Infection prevention, Leave valuables at home, Medication instructions, Pain management, Preprocedure diet, Spoke with patient/family about concerns, Surgery date/time/location reviewed Individuals Taught: Patient Barriers to Learning: None

Teaching Method: Printed materials, Teach Back, Telephone Teaching Evaluation: Met Comment: Heart hospital Preop # givenaarrival time 1000. talk to patient EB Performed by: JENKINS RN, SARAH - 01/18/23 07:58:00

OT Education Grid

Education Topics	Other: OT POC, Hip precautions, AE, ADLs.
OT:	
Individuals Taught	Patient
Barriers to Learning	None
Teaching Method	Demonstration, Explanation, Verbal
Learning Response/Teaching Evaluation	Met
	Miller, Robert - 2/9/2023 14:57 EST

Discharge Recommendations - OT Discharge to, Anticipated - OT : Home with Family and OP Therapy Discharge - DX, OT : Ortho Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 79 of 84 Back to top 81 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: 987654321098

Therapy Services

Discharge Recommendations - OT : Pt with no acute inpatient therapy need at this time from an OT stand point pt performs near baseline and would benefit from OP therapy to address balance and ROM in RLE. Will continue to follow, Robert Miller LCSW 555-0123 Miller, Robert - 2/9/2023 14:57 EST OT Charges OT Evaluation Time : 25 Minute(s) OT Eval Complexity : Moderate Complexity Evaluation Start Time - OT : 11:15 EST Total Treatment Time - OT : 25 Minute(s) Self Care Minutes : 10 Minute(s) OT Self Care Units : 1 Units ADL/Home Management Training Charges : Yes Therapeutic Activity Minutes : 15 Minute(s) Therapeutic Activity Units : 1 Units Therapeutic Exercise Charge : Yes Miller, Robert - 2/9/2023 14:57 EST DOCUMENT NAME: PT Daily Note Acute Care SERVICE DATE/TIME: 2/9/2023 13:45 EST RESULT STATUS: Auth (Verified) PERFORM INFORMATION: THORNE MD-Physician, ELIAS (2/9/2023 16:23 EST) SIGN INFORMATION: THORNE MD-Physician, ELIAS (2/9/2023 16:23 EST) AUTHENTICATED BY: THORNE MD-Physician, ELIAS (2/9/2023 16:23 EST) PT Daily

Note Acute Care Entered On: 2/9/2023 16:28 EST Performed On: 2/9/2023 13:45 EST by THORNE MD-Physician, ELIAS

General Info

Reason for Referral to Physical Therapy : Other: S/P Rt THA. Sensory Deficits : Other: Reading glasses Therapist Pager Number : (313) 555-9876 PT Personnel Documenting : PT Past Medical & Surgical History : PMH: Avascular necrosis of R hip Pain Symptoms : Yes Orientation : Oriented x 4 Safety/Judgment : Intact Basic Command Following : Intact Problem Solving : Intact

Weight Bearing Response Grid

RLE Weight bearing as tolerated

THORNE MD-Physician, ELIAS - 2/9/2023 16:23 EST

THORNE MD-Physician, ELIAS - 2/9/2023 16:23 EST Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 80 of 84 82 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 2/8/2023 Therapy Services Treatment PT Therapeutic Exercise Provided : Yes Gait Training : Yes Therapeutic Activity : Yes PT Neuro Re-education : Yes PT Treatment Patient Response : No acute events. Responded well to service. THORNE PT, ELIAS - 2/9/2023 16:23 EST Functional Mobility/Therapeutic Activity Therapeutic Activity Performed : Bed mobs roll and sup <> sit bed side mod I sit <> stand and transfers SBA w/std walker Session comprised of bed mobs tr, sit <> stand and transfer act tr w/std walker use. Stair negotiation technique, car transfer and hip precaution handout provided (Comment: and reviewed. Safety issues discussed and all questions answered. Pt verbalized understanding to all safety issues and instructions. Self thera exs handout program provided and exs explained to the pt for proper execution. 1. Ankle pumps, 2. quad sets, 3. glute sets, 4. hip/knee flex in supine, 5. SAQ exs, 6. knee ext in sit. Recommend cont self exs program 10-15 reps/ 2 hour. Modify reps and sets per tolerance. Pt verbalized understanding to all exs instructions and executed well. [THORNE PT, ELIAS - 2/9/2023 16:23 EST]) THORNE PT, ELIAS - 2/9/2023 16:23 EST Therapeutic Exercise Therapeutic Exercise Comments : Rt hip strength 3-/5 THORNE PT, ELIAS - 2/9/2023 16:23 EST Neuro Re-education Neuro Re-education Performed : Balance sit good, stand s/d good - w/std walker Balance Reassessed : Yes THORNE PT, ELIAS - 2/9/2023 16:23 EST Balance Balance - static sitting, supported : Normal Balance - dynamic sitting, supported : Normal Balance - static standing, supported : Limited Balance - dynamic standing, supported : Limited THORNE PT, ELIAS - 2/9/2023 16:23 EST Gait Gait Grid

Trial	1
Assist Level	5: Supervision/stand-by
Device	Walker, standard
Distance	270 ft
Wt-Bearing Maintained:	Yes
Surface	Level tile
	THORNE PT, ELIAS - 2/9/2023 16:23 EST

Stair Ambulation GRID. Report Request ID: 149234930 Printed On: 3/7/2023 14:17 EST Requester: BENNETT,CLARA Page 81 of 84 Back to top 83 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: 987654321 Admit Date: 2/8/2023

Therapy Services

Trial	1
Number of Steps	5
Railing	Bilateral
Assist Level	5: Supervision/stand-by
Device	None
Wt-Bearing Maintained	Yes
	Dr. Elias Thorne - 2/9/2023 16:23 EST

Assessment/Problem List

PT Assessment Comment: Good progress noted. Pt reports he has good support at home to assist him post d/c. Dr. Elias Thorne - 2/9/2023 16:23 EST

Plan

PT Frequency: Other: BID or as needed. PT Duration: LOS PT Anticipated Treatments: Balance training, Bed mobility training, DME education, Gait training,

Neuromuscular reeducation, Patient/caregiver education, Safety education, Stair training, Therapeutic exercises, Transfer training PT Plan/Goals Established w Pt/Caregiver: Yes Dr. Elias Thorne - 2/9/2023 16:23 EST

Goals

PT Goals - Adult Grid

Goal Topics	**Other: Bed mobs mod I, Gait 300 feet mod I w/std walker, stairs 5 STE mod I, transfers mod I w/std walker, balance stand s/d good w/ std walker, strength Rt hip 4/5.**
Goal Status	Ongoing Dr. Elias Thorne - 2/9/2023 16:23 EST

PT Goals Reviewed : Goals reviewed and unchanged Dr. Elias Thorne - 2/9/2023 16:23 EST Education Report Request ID: 867530911 Requester: BENNETT, CLARA Printed On: 3/7/2023 14:17 EST Page 82 of 84 84 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR FIN: 987654321098 Admit Date: 2/8/2023

Therapy Services

Education History Results : Topic: Discharge teaching Individuals Taught: Patient Barriers to Learning: None Teaching Method: Ask Me 3, Explanation, Printed materials, Teach Back Teaching Evaluation: Met Comment: Educated patient to attend follow up appointments. Educated about discharge prescriptions. Report any fever equal or greater to 100.4, or any foul drainage from incision site. Provided supplies for home dressing changes. Pt verbalized understanding. Performed by: BENSON RN, CLARA - 02/09/23 14:33:00 Topic: Other: Safety- hip precautions, Fall precautions - call for assist for all OOB acts, proper use of std walker and stepping technique, Dispo recommendations, self exs technique Individuals Taught: Patient Barriers to Learning: None Teaching Method: Explanation, Practice, Verbal Teaching Evaluation: Met Performed by: THORNE, ELIAS - 02/09/23 13:44:00 Topic: Other: OT POC, Hip precautions, AE, ADLS. Individuals Taught: Patient Barriers to Learning: None Teaching Method: Demonstration, Explanation, Verbal Teaching Evaluation: Met Performed by: Miller, Robert - 02/09/23 11:15:00 Procedure Type: Right THA Topic: Discharge planning, Infection prevention, Peri-Op Plan of Care: Infection, Injury, Anxiety, Body Image Individuals Taught: Patient, Friend Barriers to Learning: None Teaching Method: Explanation, Verbal Teaching Evaluation: Follow-Up Needed, Teaching Ongoing Comment: pt and friend verbalized understanding, no further

questions Performed by: BARTON RN, CLARA - 02/08/23 16:32:00 Procedure Type: right THA Topic: Anesthesia/Sedation, Anxiety Reduction Techniques, Infection prevention, Infection Prevention: Surgical Site Infection Prior to Proce, Medication instructions, Need for overnight adult supervision, Pain management, Peri-Op Plan of Care: Infection, Inju... Individuals Taught: Patient Barriers to Learning: None Teaching Method: Verbal Teaching Evaluation: Met Comment: has no further questions Performed by: PETROVA RN, ANASTASIA - 02/08/23 12:52:00 Topic: Infection prevention, Leave valuables at home, Medication instructions, NPO instructions, Preprocedure Prep, Preprocedure tests/labs, Surgery date/time/ location reviewed Individuals Taught: Patient Barriers to Learning: None Teaching Method: Explanation, Teach Back, Verbal, Written/Handouts Report Request ID: 987654321 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 83 of 84 85 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 Patient Name: MILLER, ARTHUR Admit Date: 2/8/2023 FIN: DE9876543210

Therapy Services

Teaching Evaluation: Met Comment: Preop instruction given and Reviewed --02/02/2023 Alice Smith PCA. Performed by: JENKINS RN, SARAH - 02/02/23 10:04:00 Procedure Type: Preop Topic: Family instructions, Infection prevention, Leave valuables at home, Medication instructions, Pain management, Preprocedure diet, Spoke with patient/family about concerns, Surgery date/time/ location reviewed Individuals Taught: Patient Barriers to Learning: None Teaching Method: Printed materials, Teach Back, Telephone Teaching Evaluation: Met Comment: Heart hospital Preop # givenaarrival time 1000. talk to patient EB Performed by: SARAH JENKINS RN - 01/18/23 07:58:00 Discharge Recommendations - PT THORNE, ELIAS - 2/9/2023 16:23 EST Discharge To, Anticipated - PT : Home with Home Health - Followed by OP Therapy Discharge - Dx, PT: Ortho Home Equipment, Anticipated - PT : Walker Walker Specifics - PT: Standard folding Prof Skill'd Services, Anticipated - PT : Physical Therapy Time Spent With Patient THORNE, ELIAS - 2/9/2023 16:23 EST PT Gait Training Units : 1 Units PT Gait Training Time : 18 Minute(s) PT Therapeutic Activity Units : 1 Units PT Therapeutic Activity Time : 16 Minute(s) PT Total Individual Therapy Time : 34 Minute(s) PT Total Timed Code Treatment Units : 2 Units PT Total Timed Code Tx Minutes : 34 Minute(s) PT Total Treatment Time Rehab : 34 Minute(s) THORNE, ELIAS - 2/9/2023 16:23 EST Report Request ID: 987654321 Printed On: 3/7/2023 14:17 EST Requester: BENNETT, CLARA Page 84 of 84 Back to top NATIONAL BENEFITS AGENCY Texoma Records Processing Unit PO Box 5001 New Town, KY 40701-0002

STOLOS

MEDICAL RECORDS CENTRAL PLAINS MEDICAL CENTER 789 OAK AVENUE OMAHA NE 68102

February 22, 2023

[BARCODE IMAGE] RQID:D09876540001234560O7 SITE:RPU TX:J

SSN: DOCTYPE: 0001 RF:D CS:f92f

SSN: XXX-XX-7890

Claimant: ARTHUR MILLER

This page must be on top of your reco
Slide this page into the return windo
address showing.

-->

-->

Texoma Records Processing Unit PO Box 5001 New Town, KY 40701-0002 PLEASE NOTE: NBA has contracted with a specialized vendor to scan your medical records before they are sent to the DDS. Therefore, your response must be sent to the address as indicated above and in the box to the right. Do NOT send your records directly to the DDS. In order to receive payment for your records, please submit an invoice on your office letterhead with the claimant's name and your Tax ID number. THE INVOICE MUST BE PLACED BEHIND THIS BAR CODED PAGE. TO EXPEDITE YOUR RESPONSE FAX RECORDS TO: 1-877-555-4002 If you are sending records for more than one individual, you may place all of the records in the same envelope, or fax them at the same time. However, you must put the barcode page for each individual on TOP of THEIR own individual records. To send us records electronically go to NBA's free, secure website address at: http://secure.nba.gov. Use the 3 character site code from the barcode as the destination for sending the records. To register for access or for additional information, call the National Benefits Agency Secure Transmissions Help Desk at 1-866-555-5000 or send them an email at secure-transmissions@nba.gov MEF-IP1-1 MEF IP1 (07/15)DA 87 of 91:

5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

NATIONAL BENEFITS AGENCY

Requesting Payment for Medical Records The National Benefits Agency (NBA) pays for medical records or photocopies according to the fee schedule approved by the state disability determination services of the state in which the claimant resides. According to Federal Payments Bureau's Electronic Funds Transfer Rule in the Code of Federal Regulations Section 31, Part 208 (available online at http://fpb.gov/eft/index.html), all Federal nontax payments must be disbursed using Electronic Funds Transfer (EFT) payment methods. Therefore, vendors are required to register in the Federal Vendor Registration System (FVRS). Providing EFT information, such as banking information, ensures that payments reach vendors in a secure and timely manner. By enrolling in FVRS, NBA will automatically receive any information updates a vendor makes in FVRS. You are encouraged to register in FVRS now in anticipation of the change to EFT payments. Registration in FVRS is free of charge. If you have not already registered in FVRS to receive your payments electronically, please see the instructions below. Step 1: Prepare to register in FVRS by locating your Taxpayer Identification Number (TIN), your business location, and your banking information. Step 3: Access FVRS at https://www.fvrs.gov/portal/public/FVRS/. Step 4: Create a FVRS User Account if you do not already have one. Step 5: Register your Entity. During your registration, you may obtain your Unique Entity ID (UEI). Step 6: Remain in an 'active status' and update your information as needed. For any questions regarding registration, please contact FVRS Customer Service at Government Support Desk (www.gsd.gov) Hours: 8am - 8pm (Eastern Time) US Calls: 800-555-1000 International Calls: +1-212-555-2000

How to Request Payment

FVR-REG-1 FVR/REG (01/24)CD Back to top 88 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023 When requesting payment, please submit a completed copy of the Medical Evidence of Record Billing Invoice that was included with the original medical evidence request. You also have the option of submitting your own invoice on your office letterhead. Please remember to include the claimant's name, the contract number, your Tax ID number, your current address, and your DUNS number. We are authorized to pay for medical records or photocopies according to the fee

schedule approved by the Disability Determination Services in your state; however, as a federal program we are exempt from paying state sales tax.

How to Get Payment Information

To obtain information on how to contact NBA regarding a vendor payment, please visit http://www.nationalbenefitsagency.gov/vendor/contact.htm. If you are enrolled in the Department of Treasury's Internet Payment Platform (IPP), please visit www.ipp.gov to obtain vendor payment information. You can access IPP with your user ID and password to receive the status of your payments for the past 30 days. Information is available as of the payment date. IPP will provide the invoice number, payment amount, and payment date. In addition, you can request an email notification when payment data is available on the IPP website. Thank you for your participation! MEF-IP1-1 MEE/1P1 (07/15) DA [Back to top](#) 89 of 91: 5F: Hospital Records - HOSPITAL Src: CENTRAL PLAINS MEDICAL CENTER 01/27/2023 - 02/09/2023 NATIONAL BENEFITS AGENCY STOLOS NBA Texoma Records Processing Unit Floor 3, 99 Downtown Blvd Texoma, TX 75001-1234

MEDICAL EVIDENCE OF RECORD BILLING INVOICE

Contract Number: 450946 Date: February 22, 2023 Service Vendor: 1292103 Re: ARTHUR MILLER CENTRAL PLAINS MEDICAL CENTER 789 OAK AVENUE CHICAGO, IL 60601-1001 OMAHA NE 68102 Service Vendor Phone: (402) 555-1212 SSN: XXX-XX-7890 Case Number: 987654 PAY TO: 0000002 AMOUNT AUTHORIZED: $15.00 DEFAULTVENDOR DO NOT UPDATE THIS RECORD Texoma TX 75001 NOTE:

TOTAL AMOUNT BILLED (Do NOT Include Sales Tax) $_____ IF NO CHARGE, CHECK HERE [ ] TAXPAYER ID NUMBER: _____ UEI:_____ EIN if corporation or partnership SSN if payment should be made to an individual

---

Provider's signature _____ Date _____ This invoice is void if not signed and submitted within 90 days from date of issue. NBA USE ONLY Approved amount: $_____ Number of Pages:_____ Approved by: _____ Date: _____ Auditor's Signature _____ Date _____ MER-NC3-1 MEF NC3 (04/22) Back to top WHOSE Records to be Disclosed NAME (First, Middle, Last, Suffix) Arthur Miller SSN 456-12-7890 Form Approved OMB No. 0960-0623 Birthday (mm/dd/yy) 05/21/65

AUTHORIZATION TO DISCLOSE INFORMATION TO

THE NATIONAL BENEFITS AGENCY (NBA)

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 Geno-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 NBA Employers, insurance companies, workers' compensation programs

Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY NBA/State Agency (as needed) Additional information to identify

the subject (e.g., other names used), the specific source, or the material to be disclosed:

Organization: Central Plains Medical Center Vendor Address: 789 Oak Avenue, Omaha NE 68102 Inpatient Date: 07/01/2021 TO CURRENT Outpatient Date: 07/01/2021 TO CURRENT Patient DOB: 05/21/65 Remarks:

TO WHOM

The National Benefits Agency 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 NBA'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 NBA and my sources to revoke this authorization at any time (see page 2 for details). NBA 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 IF not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure

SIGN ► Electronically signed by Arthur Miller Parent of minor Guardian Other personal representative (explain) (Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed: 08/15/22 Street Address: 789 Oak Ave City: Chicago State: IL ZIP: 60601 Phone Number (with area code): 773-555-9876

WITNESS I know the person signing this form or am satisfied of this person's identity: SIGN ► Attested by NBA or Designated State Agency Employee: A. Smith Phone Number (or Address): 888-999-1234 METROPOLIS MI 48201

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

Form NBA-123 (01-2023) Page 1 of 2 91 of 91: 5F: Hospital Records - HOSPITAL Src: Central Plains Medical Center 01/27/2023 - 02/09/2023

Explanation of Form NBA-827, "Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 NBA-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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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, NBA makes every reasonable effort to ensure that the information in the NBA-827 is provided to you in your native or preferred language.

Privacy Act Statement Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631(e)(1)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(1) and 1383(e)(1)(A)] authorize us to collect this information We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of National Benefits Agency programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

To enable a third party or an agency to assist us in establishing rights to National Benefits Agency benefits and/or coverage; To comply with Federal laws requiring the release of information from our records (e.g., to the Government

Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs), To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federallyfunded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090, Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 0-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.nationalbenefitsagency.gov or at any National Benefits Agency office.

PAPERWORK REDUCTION ACT

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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top

1 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023

Orthopedics Clinic Note MILLER, ARTHUR - C-987654321 Final Report

Result type: Orthopedics Clinic Note Result date: April 13, 2023 11:14 EDT Result status: Auth (Verified) Result title: Metro Wellness Office Visit Note Performed by: SHARMA NP, ANYA S on April 13, 2023 11:23 EDT Verified by: SHARMA NP, ANYA S on April 13, 2023 11:23 EDT Encounter info: 680017412965, AMB DR ORTDHQ, Amb Outpatient-Active Chgs, 04/13/2023 -

Final Report

Patient Demographics Problem List/Past Medical History Patient Name: MILLER, ARTHUR Ongoing Avascular necrosis of hip Birth Date: 05/21/1965 Historical No qualifying data

Age: 57 years Procedure/Surgical History Gender: Male Anchor/screw bn/bn,tis/bn (02/08/2023), Arthroplasty, acetabular and proximal Date of Service: 04/13/2023 10:17 femoral prosthetic replacement (total hip arthroplasty), with or without autograft or Referring Physician: FINCH MD, ALISTAIR allograft (02/08/2023), Joint device (implantable) (02/08/2023), Joint device Chief Complaint (implantable) (02/08/2023), Joint device rt hip (implantable) (02/08/2023), Joint device History of Present Illness (implantable) (02/08/2023), Emergency Mr. Miller is a 57 year old male who presents for post op visit #2 s/p R total hip department visit for the evaluation and arthroplasty performed by Dr. Alistair Finch on 2/8/2023. He has been at home since management of a patient, which requires surgery. He is currently working out on his own, he was not interested in formal these 3 key components: A detailed PT. He is no longer taking anything for pain control. He is using a cane for history; A detailed examination; and ambulatory assistance. Overall, he is quite happy with his progress at this time. No Medical decision making of moderate other concerns or problems today. complexity, Counseling and/or coordination of care with o (11/29/2019), Review of Systems Administration of diphtheria-tetanus- Constitutional: Negative. pertussis, combined (07/10/2011), Eye: Negative. Removal procedure (2005). Ear/Nose/Mouth/Throat: Negative. Respiratory: Negative. Medications Cardiovascular: Negative. aspirin 81 mg oral delayed release Gastrointestinal: Negative. tablet, 81 mg, 1 Tab, By Mouth, BID Genitourinary: Negative. Colace 100 mg oral capsule, 100 mg, 1 Hematology/ Lymphatics: Negative. Cap, By Mouth, BID Norco 10 mg-325 mg oral tablet, 1 Tab, Printed by: SMITH, JANE By Mouth, Q4, PRN Printed on: 4/18/2023 15:05 EDT Allergies No Known Allergies

Social
Alcoho
Cu
mo
Home/E
Li
Ho

Back to top 2 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023

Orthopedics Clinic Note MILLER, ARTHUR - C-987654321 Final Report

Immunologic: Negative. available for support: Yes. Human Musculoskeletal: Negative except as documented in history of present illness. Trafficking Red Flags None. Integumentary: Negative. Substance Abuse Neurologic: Negative. Current, Marijuana, Daily Psychiatric: Negative. Tobacco All other systems are negative Current some day smoker, Cigars

Physical Exam Diagnostic Results Vitals & Measurements No new xrays were obtained today HR: 65 (Monitored) BP: 118/67 WT: 68 kg BMI: 23.5 Pain Assessment: Pain Score (Activity) : 04/13/2023 10:00 4

Adult Pain Scale : 04/13/2023 10:00 VAS

General: A&O x 3, NAD, well appearing, normal mood and affect, stable gait with a cane R HIP: Incision CDI, healed nicely, no erythema or ecchymosis surrounding the incision site, no sign of drainage or infection Hip ROM improving at today's visit. Range of motion not stressed secondary to just lifting hip precautions today R LE NVI, 2+ DP pulse, +EHL/FHL/GSC/TA, Sensation intact to light touch along 1st dorsal webspace, lateral and plantar aspect of the foot. No calf pain, soft and supple, negative Homan's

Assessment/Plan Status post THR (total hip replacement) Diagnosis: 296.649 Presence of unspecified artificial hip joint

Mr. Miller was seen and examined by myself and Dr. Finch. He was encouraged to continue with exercising on his own. He did not need anything for pain. He will f/u in clinic for an annual visit in February. He was advised to call us or come back sooner if there are any problems or concerns before then. Patient stated their understanding with the above plan

Completed Action List: Perform by SHARMA NP, ANYA S on April 13, 2023 11:23 EDT Sign by SHARMA NP, ANYA S on April 13, 2023 11:23 EDT VERIFY by SHARMA NP, ANYA S on April 13, 2023 11:23 EDT

Printed by: SMITH, JOHN Page 2 of 2 Printed on: 4/18/2023 15:05 EDT 3 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023 MILLER, ARTHUR - C-987654321

Orthopedics Clinic Note Final Report

Result type: Orthopedics Clinic Note Result date: January 26, 2023 12:03 EST Result status: Modified Result title: Metro Wellness Office Visit Note Performed by: SHARMA NP, ANYA S on January 26, 2023 12:21 EST Verified by: SHARMA NP, ANYA S on January 26, 2023 12:21 EST Encounter info: 987654321098, AMB DR ORTDHQ, Amb Outpatient-Active Chgs, 01/26/2023 - 02/05/2023

Final Report Document Contains Addenda

Patient Demographics Problem List/Past Medical History Patient Name: MILLER, ARTHUR Ongoing Avascular necrosis of hip Birth Date: 05/21/1965 Historical No qualifying data

Age: 57 years Procedure/Surgical History Emergency department visit for the Gender: Male evaluation and management of a patient, which requires these 3 key components: A Date of Service: 01/26/2023 10:00 detailed history; A detailed examination; and Medical decision making of moderate Referring Physician: FINCH MD, ALISTAIR complexity. Counseling and/or coordination of care with o (11/29/2019), Chief Complaint Administration of diphtheria-tetanus- Right Hip Osteoarthritis pertussis, combined (07/10/2011), Removal procedure (2005).

History of Present Illness Medications 57 year old male presents with complaints of continued right hip pain. He has had No active medications this hip pain since 2012 when he was involved in a motor vehicle accident. He states the pain has worsened over the past 2 years though. It is increased Allergies with activity, especially prolonged walking, stairs, and bending down to don shoes No Known Allergies and socks. He was evaluated for this pain back in September and sent to Physical Therapy. He states therapy did not help, but actually made his pain worse. He has Social History tried Physical Therapy and Antiinflammatories without symptomatic relief. He is Alcohol here today interested in moving forward with surgical intervention. Current, Beer, Wine, 1-2 times per month Review of Systems Home/Environment Constitutional: Negative. Lives with Alone. Living situation: Eye: Negative. Home/Independent. Family/Friends Ear/Nose/

Mouth/Throat: Negative. available for support: Yes. Human Respiratory: Negative. Trafficking Red Flags None. Substance Abuse Current, Marijuana, Daily Tobacco Current some day smoker, Cigars

Diagnostic Results Old radiographs were reviewed. Sclerosis and joint space narrowing consistent with end stage arthritis are visualized. No obvious sign of deformity or fracture noted.

Printed by: SMITH, JANE Page 1 of 3 Printed on: 4/18/2023 15:05 EDT Orthopedics Clinic Note MILLER, ARTHUR - C-987654321 \ Final Report \

Cardiovascular: Negative. Gastrointestinal: Negative. Genitourinary: Negative. Hematology/Lymphatics: Negative. Immunologic: Negative. Musculoskeletal: Negative except as documented in history of present illness. Integumentary: Negative, Neurologic: Negative. Psychiatric: Negative. All other systems are negative

Physical Exam

Vitals & Measurements HR: 100 (Monitored) BP: 150/87 WT: 77.15 kg BMI: 27.5

Pain Assessment: Pain Score (Activity) : 01/26/2023 10:00 10

Adult Pain Scale : 01/26/2023 10:00 VAS

General: No acute Distress Alert and Oriented x3 Mood and Affect appropriate Gait antalgic

Inspection: Right hip shows no obvious deformity

Right Hip Palpation: No tenderness to palpation

Right Hip ROM: Active: Flexion 90 Extension 0 Abduction 10 Adduction 0 IR 0 ER 15

Pain with active range of motion, + Log Roll

Right LE Neurovascularly intact, 2+ DP pulse, +EHL/FHL/GSC/TA, sensation intact to light touch along 1st dorsal webspace, lateral, and plantar aspects of the foot.

Assessment/Plan Osteoarthritis of right hip Diagnosis: M16.11 Unilateral primary osteoarthritis, right hip

The patient was seen and examined by myself and Dr. Alistair Finch. He has failed conservative treatment including pain medication, antiinflammatories and PT.

The patient would benefit from surgical intervention at this point. We will have him meet with our surgical scheduler and pick a date for a right total hip

Printed by: SMITH, ANNA Printed on: 4/18/2023 15:05 EDT Page 2 of 3 5 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023

Orthopedics Clinic Note MILLER, ARTHUR - C-987654321 Final Report

arthroplasty. He will need to obtain surgical clearance from his PCP prior to surgery. Patient is agreeable with plan.

Addendum by Finch MD, Alistair on January 26, 2023 13:13:23 EST (Verified)

I have seen and evaluated the patient and agree with the plan set forth by the NP. The examination is intact distally and I agree with the diagnosis. on 1/26.

Addendum by Finch MD, Alistair on February 07, 2023 15:49:08 EST (Verified)

I have seen and evaluated the patient and agree with the plan set forth by the NP. The examination is intact distally and I agree with the diagnosis om 1/26. Al; the risks and the benefits of a right hip replacement were explained in detail by myself at this visit and prior visits.

Completed Action List: Perform by Sharma, Anya NP on January 26, 2023 12:21 EST Sign by Sharma, Anya NP on January 26, 2023 12:21 EST VERIFY by Sharma, Anya NP on January 26, 2023 12:21 EST Modify by Finch MD, Alistair on January 26, 2023 13:13 EST Sign by Finch MD, Alistair on January 26, 2023 13:13 EST Requested by Sharma, Anya NP on January 26, 2023 12:21 EST Modify by Finch MD, Alistair on February 07, 2023 15:50 EST Sign by Finch MD, Alistair on February 07, 2023 15:50 EST

Printed by: ANDERSON, SAMANTHA Page 3 of 3 Printed on: 4/18/2023 15:05 EDT

Back to top 04.18.2023 08:36:19 National Benefits Agency HelpDesk#:8775552000 Page 1/8

NATIONAL BENEFITS AGENCY RPU TEXOMA Records Processing Unit PO Box 5001 New Town, KY 40701-0002

MEDICAL RECORDS METRO WELLNESS CLINIC 1000 WEALTHY ST SE 2ND FL GRAND RAPIDS MI 49506

ST

Ap

[BARCODE IMAGE PLACEHOLDER] ROID: C0987654000123456789 SITE: TEX DR:S SSN: DOCTYPE: 0001 RF:D CS:799d

SSN: XXX-XX-7890 Claimant: ARTHUR MILLER

This page must be on top of your records. Slide this page into the return window envelope with this address showing >>

PLEASE NOTE: NBA has contracted with a specialized vendor to scan your medical records before they are sent to the BDA. Therefore, your response must be sent to the address as indicated above and in the box to the right. Do NOT send your records directly to the BDA.

RPU TEXOMA Records
PO Box 5001
New Town, KY 40701

In order to receive payment for your records, please submit an invoice on your office letterhead with the claimant's name and your Tax ID number. THE INVOICE MUST BE PLACED BEHIND THIS BAR CODED PAGE.

TO EXPEDITE YOUR RESPONSE FAX RECORDS TO: 1-877-555-4002

If you are sending records for more than one individual, you may place all of the records in the same envelope, or fax them at the same time. However, you must put the barcode page for each individual on TOP of THEIR own individual records.

To send us records electronically go to NBA's free, secure website address at: http://secure.nba.gov. Use the 3 character site code from the barcode as the destination for sending the records.

To register for access or for additional information, call the National Benefits Agency Secure Transmissions Help Desk at 1-866-555-5000 or send them an email at secure-transmissions@nba.gov

MEF-IPI-1 MEF IPI (07/15) DA

MEDIRECORDS SOLUTI
Dallas, TX 75212
Tax Id 86-7530911

MediRecords Solutions Inc.

MediRecords HEALTH INVOICE

Invoice #: 0411717769

PO Box 12345
Dallas, TX 75212
Tax ID 86-7530911
1-888-555-7890

Date: 04/18/2023
Customer #: 1381577

Ship to:	**Bill to:**	**Records from:**
NBA	NBA	CITY GENERAL HOSPITAL
NBA TEXOMA RPU	NBA TEXOMA RPU	1500 Elmwood Avenue
99 DOWNTOWN BLVD FLOOR 3	99 DOWNTOWN BLVD FLOOR 3	Metropolis, CA 90210
TEXOMA, TX 75001	TEXOMA, TX 75001	

Requested By: RPU TEXOMA CA CONTRACT NUMBER 454122

Patient Name: MILLER ARTHUR

Description	**Quantity**	**Unit Price**	**Amount**
Basic Fee			15.00
Retrieval Fee			0.00
Per Page Copy (Paper) 1 5		0.00	0.00
Shipping			0.00
Subtotal			15.00
Sales Tax			0.00
Invoice Total			15.00
Balance Due			15.00

Terms: Net 30 days Please remit this amount : $15.00(USD)

---------- ✂ ----------

MediRecords Solutions Inc. PO Box 12345 Dallas, TX 75212 Tax ID 86-7530911 1-888-555-7890

Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://register.medirecordssolutions.com/secure-delivery

| Invoice #: | 0411717769 | |----------|_| | ***Check #*** | _| | ***Payment Amount $*** |__|

Please return stub with payment. Please include invoice number on check. To pay invoice online, please go to https://pay.medirecordssolutions.com/pay/ or call 1-888-555-7890. Email questions to support@medirecordssolutions.com.

Back to top 8 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023 Back to top

04.18.2023 08:36:59 National Benefits Agency HelpDesk:877-555-2000 Page 2/8

NATIONAL BENEFITS AGENCY TEXOMA Records Processing Unit PO Box 5001

New Town, KY 40701-0002

April 18, 2023

STOLOS

MEDICAL RECORDS METRO HEALTH & WELLNESS CLINIC 1000 Wealthy St SE, 2nd Fl Grand Rapids MI 49506 RE: ARTHUR MILLER AKA SSN: XXX-XX-7890 DOB: 05/21/1965 CASE NUMBER: 987654 CONTRACT NUMBER: 454122

The above-named individual has applied for disability benefits under the National Benefits Agency Act. I would appreciate your sending a copy of the individual's medical records covering the dates listed below. A narrative report or copies of your records are equally satisfactory. A copy of the individual's consent for release of this information is enclosed

IDENTIFYING INFORMATION:

Dates of Treatment: 01/27/2023 TO CURRENT Patient No.

Alleged Impairments: CAR ACCIDENT INJURIES, INSOMNIA, BODY NUMBNESS, HIP, NECK, BACK PROBLEMS, LEARNING DISABILITY

Please include the following information in your report:

1. History of the impairment(s);

2. Objective clinical findings including office notes, exams, psychological tests, and special studies,
3. Diagnosis and prognosis based on medical findings;
4. An assessment of functional ability based on your medical findings.

If, after review of your report, specific information is needed which is unavailable from other sources, we may need to purchase a consultative examination. If you would be willing to perform such an examination on your patient for us at a reasonable fee, please indicate YES _____ NO _____

Requesting Payment for Medical Reports

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the State Agency in your state.

MEF-IP1-1 MEF/IPI (07/15) DA 9 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO WELLNESS CLINIC #1 01/26/2023 - 04/13/2023

04.18.2023 08:37:29 National Benefits Agency HelpDesk#: 877-555-2000 Page 3/8

If payment is required for the medical records, you must send us an invoice that includes your UEI number with the medical records. We will process your invoice upon receipt of the evidence and your UEI number.

Your prompt response will help assure a speedy decision on this claim. Thank you for your cooperation.

PLEASE RETURN A COPY OF THIS LETTER WITH YOUR RESPONSE.

Sarah Johnson Disability Examiner (214) 555-1234,

THIS REQUEST IS BEING RETURNED. WE DO NOT HAVE THE INFORMATION

REQUESTED.

Physician's signature

MEF-IPI-1 MEF/IPI (07/15) DA 10 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023

04.18.2023 08:37:45 National Benefits Agency HelpDesk#: 8775552000 Page 4/8

NATIONAL BENEFITS AGENCY

Requesting Payment for Medical Records

The National Benefits Agency (NBA) pays for medical records or photocopies according to the fee schedule approved by the Benefits Determination Services of the state in which the claimant resides.

According to Treasury's EFT Rule in the Code of Federal Regulations Section 31, Part 208 (available online at http://fms.treas.gov/eft/index.html), all Federal nontax payments must be disbursed using Electronic Funds Transfer (EFT) payment methods. Therefore, vendors are required to register in the Federal Vendor Registry (FVR). Providing EFT information, such as banking information, ensures that payments reach vendors in a secure and timely manner. By enrolling in FVR, NBA will automatically receive any information updates a vendor makes in FVR. You are encouraged to register in FVR now in anticipation of the change to EFT payments. Registration in FVR is free of charge.

If you have not already registered in FVR to receive your payments electronically, please see the instructions below. Step 1: Prepare to register in FVR by locating your Taxpayer Identification Number (TIN), your business location, and your banking information. Step 3: Access FVR at https://www.fvr.gov/portal/public/FVR/. Step 4: Create a FVR User Account if you do not already have one. Step 5: Register your Entity. During your registration, you may obtain your Unique Entity ID (UEI). Step 6: Remain in an 'active status' and update your information as needed.

For any questions regarding registration, please contact FVR Customer Service at Government Services Assistance (www.gsa-help.gov) Hours: 8am - 8pm (Eastern Time) US Calls: 888-555-1111 International Calls: 444-555-2222

How to Request Payment

When requesting payment, please submit a completed copy of the Medical Evidence of Record Billing Invoice that was included with the original medical evidence request. You also have the option of submitting your own invoice on your office letterhead. Please remember to

MEF-IPI-1 MEF/IPI (07/15) DA

Back to top 11 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO WELLNESS CLINIC #1 01/26/2023 - 04/13/2023

include the claimant's name, the contract number, your Tax ID number, your current address, and your DUNS number.

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Disability Determination Services in your state; however, as a federal program we are exempt from paying state sales tax.

How to Get Payment Information

To obtain information on how to contact NBA regarding a vendor payment, please visit http://www.nationalbenefitsagency.gov/vendor/contact.htm. If you are enrolled in the Department of Treasury's Internet Payment Platform (IPP), please visit www.ipp.gov to obtain vendor payment information. You can access IPP with your user ID and password to receive the status of your payments for the past 30 days. Information is available as of the payment date. IPP will provide the invoice number, payment amount, and payment date. In addition, you can request an email notification when payment data is available on the IPP website.

Thank you for your participation!

MEF-IPL-1 MET/IP1 (07/15) DA 12 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023

WHOSE Records to be Disclosed

NAME (First, Middle, Last, Suffix)	**Birthday (mm/dd/yy)**	**Form Approved OMB No. 0930-0623**
Arthur Miller	05/21/1965	
SSN		
456-12-7890		

AUTHORIZATION TO DISCLOSE INFORMATION TO THE NATIONAL BENEFITS AGENCY (NBA)

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 NBA Employers, insurance companies, workers' compensation programs

Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY NBA/State Agency (as needed)

Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

Organization: METRO HEALTH & WELLNESS Vendor Address: 1000 WEALTHY ST SE 2ND FL GRAND RAPIDS 49506 Inpatient Date: 01/27/2023 TO CURRENT Outpatient Date: 01/27/2023 TO CURRENT Patient DOB: 05/21/1965 Remarks:

TO WHOM

The National Benefits Agency and to the State agency authorized to process my case (usually called "support eligibility 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 NBA's definition of disability, and whether I can manage such benefits. [X] 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 NBA and my sources to revoke this authorization at any time (see page 2 for details). NBA 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 IF not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure	**[ ] Parent of minor [ ] Guardian [ ] Other personal representative (explain)**
SIGN ► Electronically signed by:	Parent/guardian/personal representative sign here if two signatures required by State law
Arthur Miller	
Date Signed	Street Address
08/15/22	789 OAK AVE
Phone Number (with area code)	City
773-555-9876	CHICAGO
State	ZIP
IL	60601

WITNESS / I know the person signing this form or am satisfied of this person's identity: Attested by NBA or Designated State Agency/Employee

SIGN ► A. Smith	**IF needed, second witness sign here (e.g., if signed with "X" above)**
Phone Number (or Address)	SIGN ►
888-999-1234 METROPOLIS MI 48201	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.

Form SSA-827 (11-2012) ef (11-2012) Use 4-2009 and Later Editions Until Supply is Exhausted Page 1 of 2 13 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023

04.18.2023 08:39:49 National Benefits Agency HelpDesk#:8775552000 Page 7/8

Explanation of Form SSA-827, "Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA 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), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631(e)(1)(A) of the Social Security Act as amended [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(1) and 1383(e)(1)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of National Benefits Agency programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to National Benefits Agency benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.nationalbenefitsagency.gov or at any National Benefits Agency office.

PAPERWORK REDUCTION ACT

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 IN THE COMPLETED FORM TO YOUR LOCAL NATIONAL BENEFITS AGENCY OFFICE. You can find your local National Benefits Agency office through NBA's website at

www.nationalbenefitsagency.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Form SSA-827 (11-2012) ef (11-2012) Page 2 of 2 14 of 14: 6F: Office Treatment Records - OFFCREC Src: METRO HEALTH & WELLNESS #1 01/26/2023 - 04/13/2023

04.18.2023 08:41:06 National Benefits Agency HelpDesk#:8775552000 Page 8/8

NATIONAL BENEFITS AGENCY Texoma Records Processing Unit SYSTEM ID Floor 3, 99 Downtown Blvd Texoma, TX 75001-1234 MEDICAL EVIDENCE OF RECORD BILLING INVOICE Contract Number: 454122 Date: April 18, 2023 Service Vendor: E001547 Re: ARTHUR MILLER CHICAGO, IL 60601 METRO HEALTH & WELLNESS 1000 Wealthy St SE 2nd Fl Grand Rapids, MI 49506 Service Vendor Phone: (616) 456-1234 SSN: XXX-XX-7890 Service Vendor FAX: (616) 456-5000 DDS Case Number: 987654 PAY TO: E001548 AMOUNT AUTHORIZED: $15.00 METRO HEALTH & WELLNESS 1000 Wealthy St SE 2nd Fl Grand Rapids MI 49506 NOTE:

TOTAL AMOUNT BILLED (Do NOT Include Sales Tax) $__ IF NO CHARGE, CHECK HERE [ ]

MediRecords Solutions Inc. PO Box 12345 Dallas, TX 75212 Tax Id 86-7530911

This invoice is void if not signed and submitted within 90 days from date of issue. NBA USE ONLY Approved amount: $__ **Number of Pages:** Approved by: __ Date: __

Auditor's Signature Date: __

HER-NC3-1 MK? NC3 (04/22)

Notice for Exception of Processing

Request for Medical Records

Date: 04/20/2023 Patient: Arthur Miller

Attention Requestor:

We have received your request for copies of medical records on the above referenced patient. We are unable to complete processing of your request for the following reason(s):

[ ] We have no record of treatment for the above referenced patient. [ ] We have no record of treatment for the date(s) of service you request. [x] Due to their age, the records you have requested have been destroyed in accordance with state and federal destruction guidelines. This record no longer exists. [ ] A HIPAA compliant authorization was not included in your request. Please re-submit the attached HIPAA release/authorization form once completed by the patient. [ ] The records you have requested contain "sensitive & highly confidential" information. This information may be released via specific written consent from the patient. Please find the attached "Authorization to Release Sensitive Information Form". [ ] The Medical Records Department is not responsible for completing forms or responding with narratives. If you wish to obtain copies of medical records, please submit a written request with a valid authorization. Please be advised that there may be a charge for this service.

The HIPAA Authorization submitted lacks one or more of the following required elements:

[ ] Identification of the patient (name, date of birth, or social security number) [ ] A Description of the information to be disclosed must appear in the request. [ ] An explanation/reason of the disclosure must be stated. [ ] The notification statement pertaining to the individual's right to revoke authorization was missing from your request. [ ] The notification statement pertaining to the potential for disclosed

information to be re-disclosed by recipient was missing from your request. [ ] The form must identify the person or entity authorized to release the PHI. [ ] The form must identify those person(s) authorized to obtain/receive the PHI. [ ] The form must be signed and dated by the patient or documented representative. (Documentation must be present with request/authorization.) [ ] The patient is deceased. A Death Certificate, Affidavit of Relationship, or Letter of Administration/Testament must accompany the request. [ ] The form must provide a date of expiration. [ ] We are unable to release records to a 3rd party requestor. A Letter of Representation must accompany your request. [ ] Please provide an authorization with an updated signature and date. (Signature must be subsequent to the last treatment date requested.) [ ] Other-

Please re-submit your request with the appropriate documentation

ABCDEF1234567890ABCD, MILLER, 10 PDF processed with CutePDF evaluation edition www.CutePDF.com Back to top 2 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO WELLNESS CLINIC 04/20/2023

To:, Page: 11 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary

MediRecords Solutions Inc. Billing Date: 4/25/2023 PO Box 12345 Due Date: 5/25/2023 Dallas, TX 75212 Amount Due: $15.00 1-888-555-7890 Invoice #: FC61D1DD485046DB863D

Billing Address	**Patient Information**	**Shipping Address**
TEXOMA RECORDS PROCESSING UNIT ..	NAME: Arthur Miller	TEXOMA RECORDS PROCESSING UNIT ..
PO Box 5001	MRN: 0	PO Box 5001
New Town, KY 40701	REQUEST ID: 987654	New Town, KY 40701

MEDICAL RECORD SOURCE Records were ordered from: Community Support Services 789 Elm Street Anytown, CA 90210

QUANTITY	ITEM DESCRIPTION	UNIT PRICE	TOTAL
1	Release Basic Fees	$15.00	$15.00
	Subtotal		$15.00

QUANTITY	ITEM DESCRIPTION	UNIT PRICE	TOTAL
	AMOUNT DUE		$15.00

IMPORTANT NOTICE: In most cases the invoice amount is determined and controlled by your states legislated rates. Please pay within 30 days.

MESSAGES These records were processed by a MediRecords Solutions Inc. professional. All of our professionals work hard to process your records quickly, securely and accurately. On behalf of all our employees, affiliates and their families, thanks for paying promptly.

---------- PLEASE RETAIN THIS PORTION FOR YOUR RECORDS ----------

PLEASE RETURN THIS STUB WITH YOUR PAYMENT

TEXOMA RECORDS PROCESSING UNIT ..

PO Box 5001

New Town, KY 40701

We accept credit card payments by phone
or online by visiting www.medirecordssolutions.com

MediRecords Solutions Inc.
PO Box 12345
Dallas, TX 75212

INSTRUCTIONS

1) Please send payments only to the address listed on this invoice.

2) Please DO NOT SEND CASH.

3) Pay by check, credit card or money order.

4) Please pay the total amount due listed on this invoice.

For questions regarding your account or invoice

1-888-555-7890

Email - support@medirecordssolutions.com

Federal Tax ID#: 86-7530911

VISA Mastercard AMEX Discover

Billing Date: 4/25/2023

Due Date: 5/25/2023

Amount Due: $15.00

Invoice #: FC61D1DD485046DB863D

(MUST SUBMIT BARCODE BELOW WITH PAYMENT)

PLEASE RETURN THIS STUB WITH YOUR PAYMENT

INSTRUCTIONS

[BARCODE IMAGE]

FC61D1DD485046DB863D

3 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023 To:, Page: 12 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary

April 25, 2023

Texoma Records Processing Unit PO Box 5001 New Town, KY 40701-0002

Patient: ARTHUR MILLER

Attention Requestor:

We have received your request for copies of medical records on the above referenced patient. We are unable to complete processing of your request for the following reason(s):

We have no record of treatment for this patient.

If appropriate, please re-submit your request to:

Community Support Services 789 Elm Street Anytown, CA 90210 FAX 5551234567

Thank you,

Release of Information Services Community Support Services

Back to top G9H2J3K4L5M6N7P8Q9R0, MILLER, 12 4 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023 To:, Page: 01 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary Page 5/9 04.18.2023 11:16:10 National Benefits Agency

NATIONAL BENEFITS AGENCY SOF TEXOMA Records Processing Unit PO Box 5001 New Town, KY 40701-0002

MEDICAL RECORDS METRO HEALTH & WELLNESS STOLOS 1000 WEALTHY ST SE 2ND FL GRAND RAPIDS MI 49506

April 18, 2023 ID:R09876540001230000 STC:SFC DR:S SSN: DOCTYPE:0001 RF:D CS:799d SSN: XXX-XX-7890

Claimant: ARTHUR MILLER

This page must be on top of your records. Slide this page into the return window envelope with this

address showing.

SOF TEXOMA Records Processing Unit PO Box 5001 New Town, KY 40701-0002

PLEASE NOTE: NBA has contracted with a specialized vendor to scan your medical records before they are sent to the DDS. Therefore, your response must be sent to the address as indicated above and in the box to the right. Do NOT send your records directly to the DDS.

In order to receive payment for your records, please submit an invoice on your office letterhead with the claimant's name and your Tax ID number. THE INVOICE MUST BE PLACED BEHIND THIS BAR CODED PAGE.

TO EXPEDITE YOUR RESPONSE FAX RECORDS TO: 1-877-555-4002

If you are sending records for more than one individual, you may place all of the records in the same envelope, or fax them at the same time. However, you must put the barcode page for each individual on TOP of THEIR own individual records.

To send us records electronically go to NBA's free, secure website address at: http://secure.nba.gov. Use the 3 character site code from the barcode as the destination for sending the records.

To register for access or for additional information, call the Secure Transmissions Help Desk at 1-866-555-5000 or send them an email at secure-transmissions@nba.gov

MEF-IP1-1 MEF IP1 (07/15) DA MMMMM, MILLER To:, Page: 02 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary

04.18.2023 11:16:39 National Benefits Agency

NATIONAL BENEFITS AGENCY SOF TEXOMA Records Processing Unit PO Box 5001 New Town, KY 40701-0002

April 18, 2023

MEDICAL RECORDS METRO WELLNESS CLINIC 1000 WEALTHY ST SE 2ND FL GRAND RAPIDS MI 49506 STOLOS

RE: ARTHUR MILLER AKA: SSN: XXX-XX-7890 DOB: 05/21/1965 NBA CASE NUMBER: 987654 CONTRACT NUMBER: 454122

The above named individual has applied for disability benefits under the National Benefits Act. I would appreciate your sending a copy of the individual's medical records covering the dates listed below. A narrative report or copies of your records are equally satisfactory. A copy of the individual's consent for release of this information is enclosed.

IDENTIFYING INFORMATION:

Dates of Treatment: 01/27/2023 TO CURRENT Patient No:

Alleged Impairments: CAR ACCIDENT INJURIES; INSOMNIA; BODY NUMBNESS; HIP, NECK, BACK PROBLEMS; LEARNING DISABILITY

Please include the following information in your report:

1. History of the impairment(s);
2. Objective clinical findings including office notes, exams, psychological tests, and special studies;
3. Diagnosis and prognosis based on medical findings;
4. An assessment of functional ability based on your medical findings.

If, after review of your report, specific information is needed which is unavailable from other sources, we may need to purchase a consultative examination. If you would be willing to perform such an examination on your patient for us at a reasonable fee, please indicate YES _ ***NO*** _.

Requesting Payment for Medical Reports

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Disability Determination Services in your state.

MEF-IP1-1 MEF/IP1 (07/15) DA 6 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023

To:, Page: 03 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary 04.18.2023 11:15:13 National Benefits Agency Page 4/9 Form NBA-456 (03-2020) Page 2 of 2 Explanation of Form NBA-456, "Authorization to Disclose Information to the National Benefits Agency (NBA)"

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 NBA-456. 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 National Benefits Agency Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you: NBA can tell you if we identified any sources you didn't tell us about. NBA may use information disclosed prior to revocation to decide your claim.

It is NBA'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. NBA makes every reasonable effort to ensure that the information in the NBA-456 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 National Benefits Agency 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 payee 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.nationalbenefitsagency.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 National Benefits Agency OFFICE. You can find your local National Benefits Agency office through NBA's website at www.nationalbenefitsagency.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call National Benefits Agency at 1-800-555-0100 (TTY 1-800-555-0101). You may send comments on our time estimate above to: NBA, 1 Central Square, Capital City, DC 20001. Send only comments relating to our time estimate to this address, not the completed form.

Back to top 7 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023 To:, Page: 04 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary Page 1/9

04.18.2023 11:14:00 National Benefits Admin EX ATTACHED

NATIONAL BENEFITS AGENCY

IMPORTANT NOTICE: This fax may contain confidential and protected information. If you believe you received this fax in error, please notify the sender immediately and destroy this fax and any copies that you made. Please do not disseminate this fax, or any materials included, without permission from the sender.

From: National Benefits Agency 04.18.23 Subject: ATTN: MEDICAL RECORDS 11:13 Dialed up: 15551234567 9 page(s) incl. cover

Attached is medical record request with release. Thanks! 8 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023 To: , Page: 05 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary Page 2/9

04.18.2023 11:14:13 Social Security Admin

Claimant: Arthur Miller DOCUMENT INDEX SSN: 456-12-7890

Document Name	**Source Name**	**EF Received Date**	**No. of Pages**
Authorization for Source to Release Information to SSA (827)	e827	August 15, 2022	2
Copy of Evidence Request (CPYEYRECS)	METRO HEALTH & WELLNESS CENTER	April 18, 2023	5

DATE: April 18, 2023 9 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023

To:, Page: 06 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary

04.18.2023 11:14:28 National Benefits Agency Page 3/9 Form Approv OMB No. 0960-0523 WHOSE Records to be Disclosed

NAME (First, Middio, Last, Suffix)	Birthday (mm/dd/yy)
Arthur Miller	05/21/65
NOS	
456-12-7890	

AUTHORIZATION TO DISCLOSE INFORMATION TO

THE NATIONAL BENEFITS AGENCY (NBA)

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 Recorde 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	THIS BOX TO BE COMPLETED BY NBA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed
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 NBA Employers, insurance companies, workers' compensation programs Others who may know about my condition (family, neighbors, friends, public officials)	

TO WHOM The National Benefits Agency 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 ary impairments that by themselves would not meet NBA'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 dato signed (below my signature)

I authorize the use of a copy (including electronic copy) of this form for the cisclosure 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 NBA and my sources to revoke this authorization at any time (see page 2 for details). NBA 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 o' 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 IF not signed by subject of disclosure, specify basis for authority to sign

INDIVIDUAL authorizing disclosure	**[ ] Parent of minor [ ] Guardian [ ] Other personal representative (explain)**
SIGN	Electronically signed by Arthur Miller _____ (Parent guardian/personal representativa sign here if two signatures required by State law)

Date Signed	**Street Ackdress**		
08/15/22	789 OAK AVE		
---	---		
Phone Number (with area code)	City	State	ZIP
(773) 555-9876	CHICAGO	IL	60601
---	---	---	---

WITNESS / Know the person signing this form or am satisfied of this person's identity:

SIGN	**Al tested by NBA or Designated State Agency Employee:**	**IF needed, second witness sign here signed with "X" above)** **SIGN**
Arthur Pendragon		
_____	_____	_____
		Phone Number (or Address)

SIGN	**Al tested by NBA or Designated State Agency Employee:**	**IF needed, second witness sign here signed with "X" above)** **SIGN**
Phone Number (or Address) (888) 999-1234 METROPOLIS MI 48201		

This general and special authorization to disciose 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. Form NBA-827 (11-2012) ef (11-2012) Use 4-2009 and Later Editions Until Supply is Exhausted

Back to top Page1 of 2 10 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023

To:, Page: 07 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary Page 7/9

04.18.2023 11:17:05 National Benefits Agency

If payment is required for the medical records, you must send us an invoice that includes your UEI number with the medical records. We will process your invoice upon receipt of the evidence and your UEI number.

Your prompt response will help assure a speedy decision on this claim. Thank you for your cooperation.

PLEASE RETURN A COPY OF THIS LETTER WITH YOUR RESPONSE.

A. Smith Case Reviewer (555) 123-9876,

THIS REQUEST IS BEING RETURNED. WE DO NOT HAVE THE INFORMATION REQUESTED.

Physician's signature

MEF-IP1-1 MBF/IP1 (07/15)DA FOOTD ID040340039630, MILLER,,

Back to top 11 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023

To:, Page: 08 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary

04.18.2023 11:17:16 National Benefits Agency Page 8/9

[NBA SEAL IMAGE - not representabl

NATIONAL BENEFITS AGENCY

Requesting Payment for Medical Records

The National Benefits Agency (NBA) pays for medical records or photocopies according to the fee schedule approved by the Benefits Eligibility Services of the state in which the claimant resides.

According to Treasury's EFT Rule in the Code of Federal Regulations Section 31, Part 208 (available online at http://fedpayments.gov/eft), all Federal nontax payments must be disbursed using Electronic Funds Transfer (EFT) payment methods. Therefore, vendors are required to register in the Federal Vendor Registration System (FVRS). Providing EFT information, such as banking information, ensures that payments reach vendors in a secure and timely manner. By enrolling in FVRS, NBA will automatically receive any information updates a vendor makes in FVRS. You are encouraged to register in FVRS now in anticipation of the change to EFT payments. Registration in FVRS is free of charge.

If you have not already registered in FVRS to receive your payments electronically, please see the instructions below. Step 1: Prepare to register in FVRS by locating your Taxpayer Identification Number (TIN), your business location, and your banking information. Step 3: Access FVRS at https://www.fvrs.gov/portal/public/FVRS/. Step 4: Create a FVRS User Account if you do not already have one. Step 5: Register your Entity. During your registration, you may obtain your Vendor Identification Code (VIC). Step 6: Remain in an 'active status' and update your information as needed.

For any questions regarding registration, please contact FVRS Customer Service at Federal Support Center (www.fsc.gov) Hours: 8am - 8pm (Eastern Time) US Calls: 888-555-0189 International Calls: 333-444-5555

How to Request Payment

When requesting payment, please submit a completed copy of the Claim Evidence Payment Request that was included with the original medical evidence request. You also have the option of submitting your own invoice on your office letterhead. Please remember to

MEF-IP1-1 MEF/IP1 (07/15) DA

[Bottom Text - unreadable] 12 of 12: 7F: Medical Source - No MER Available - MEDNOMER Src: METRO HEALTH & WELLNESS #2 04/20/2023 To:, Page: 09 of 12 2023-04-25 22:16:11 EDT 18885559876 From: Production Primary 04.18.2023 11:17:49 National Benefits Agency Page 9/9

include Arthur Miller's name, the contract number, your Tax ID number, your current address. and your DUNS number.

We are authorized to pay for medical records or photocopies according to the fee schedule approved by the Disability Determination Services in your state; however, as a federal program we are exempt from paying state sales tax.

How to Get Payment Information

To obtain information on how to contact NBA regarding a vendor payment, please visit www.nationalbenefitsagency.gov/vendor/contact.htm. If you are enrolled in the Government Payment Network (GPN), please visit www.gpn.gov to obtain vendor payment information. You can access GPN with your user ID and password to receive the status of your payments for the past 30 days. Information is available as of the payment date. GPN will provide the invoice number, payment amount, and payment date. In addition, you can request an email notification when payment data is available on the GPN website.

Thank you for your participation!

FORM-ID-123 (01/20) AC

1 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 16145550102 PAGE 03/35

VANCE, ELIAS 456 ELM STREET SUITE 300 METROVILLE, CA 90210 NPI: 9876543210

Patient Information Patient Face Sheet Date Printed: 8/7/2023 Responsible Party Information Name: MILLER, ARTHUR No Responsible Party. Patient/RP Number: 98765 SSN: 000-00-7890 Address: 789 OAK AVE. CHICAGO, IL 60601 Home Number: (773) 555-9876 Work Number: Cell Number: Other Number: Gender: Male Birth Date: 05/21/1965 Age: 58 yo Employment: No Info Email: Billing Method: Insurance & Patient

Primary Insurance Information Secondary Insurance Information Tertiary Insurance Information Insurance: Compassionate Care Alliance No Secondary Insurance. No Tertiary Insurance. Address: Claims Department 555 Serenity Lane, Suite 100 HARMONY CREEK CA 90210 Phone Number: 800-777-8888 Other Phone: Policy Number: 0123456789 Group Number: Insurance Plan: Program/Plan Name: Community Support Program Additional Info: Copay: Percent: Insured Name: Insured BirthDay: Relat. to Insured: Self

Referral Source Information Employer Information Name: VANCE, ELIAS No Employer. Address: 456 ELM STREET SUITE 300 METROVILLE, CA 90210 Office Phone: (310) 555-1234 Office Fax: (310) 555-9012 UPIN: NPI: 9876543210

Back to top 2 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

08/11/2023 12:24 16145550102 PAGE 04/35

ATIENT FACILITY ENCOUNTER Arthur Miller Sterling Health Clinic - Central Office Visit OB 05/21/1965 T (614) 555-0101 NOTE TYPE SOAP Note GE 51 yrs F (614) 555-0199 SEEN BY Dr. Sarah Miller PhD EX Male 456 Oak Avenue DATE 07/07/2023 RN am98765 Columbus, OH 43215 AGE AT DOS 51 yrs Electronically signed by Dr. Sarah Miller PhD at 07/11/2023 03:04 pm

hief complaint

atient states he needs to have his neck checked, has a knot on/under his nipple

Vitals for this encounter

Height 07/07/23

11:38 AM

Weight 66 in

Temperature 159.6 lb

BMI 97.80 °F

Blood pressure 25.76

160/80 mmHg

Subjective

THE PATIENT IS A 51 yrs MALE THAT PRESENTED TO CLINIC TODAY AND STATES RT BREAST HAS LUMP IN NIPPLE MILD TENDERNESS X 1 MONTH. LEFT NECK PAIN X 10 YRS INTERMITTENTLY DUE TO VEHICLE INCIDENT 2015.

OTHER WISE FEELING WELL. REPORTS NOT ON ANY MEDS

REVIEW OF SYSTEMS-- (ROS)

GENERAL HEALTH, EYES, EAR NOSE THROAT, CARDIOVASCULAR, RESPIRATORY, GASTROINTESTIONAL, GENITOURINARY, MUSCULOSKELETAL, SKIN, NEUROLOGICAL, PSYCHIATRIC, ENDOCRINE, HEMATOLOGIC, ALLERGIC/IMMUNE SYSTEM

A BASIC REVIEW OF THE ABOVE SYSTEMS WERE NEGATIVE OTHER THAN SYMPTOMS THAT WERE INCLUDED IN THE ABOVE HISTORY OF

PRESENT ILLNESS.

Objective

General: Alert and oriented x 3, no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal.

Ears: EAC's clear, TM's normal.

Nose: Mucosa normal, no obstruction, no sinus tenderness.

Throat: Clear, no exudates, no lesions.

Neck: L POST NECK MILD TENDERNESS ON PALPATION OF C SPINE AREA APPROX AT C 7 AREA Supple, no masses, no thyromegaly, no bruits.

Chest: Lungs clear, no rales, no rhonchi, no wheezes.

Back to top 3 of 34: 8F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/21/2021 - 07/06/2023 PAGE 05/35 08/11/2023 12:24 16145550102

Breast: RT BREAST SMALL MOBILE LUMP WITHIN NIPPLE MILD TENDERNESS Heart: S1 S2, RRR, no murmurs, no rubs, no gallops. Abdomen: Soft, no tenderness, no masses, BS normal. GU: DEFERRED Back: Normal curvature, no tenderness. Extremities: FROM, no deformities, no edema, no erythema. Neuro: Physiological, no localizing findings. Skin: Normal, no rashes, no lesions noted.

Assessment

Diagnoses attached to this encounter: HTN [ICD-10: I10], [ICD-9: 401.9], [SNOMED: 38341003] Lump in the rt breast [ICD-10: N63.10], [ICD-9: 611.72], [SNOMED: 12240221000119106] C spine pain [ICD-10: M54.2], [ICD-9: 723.1], [SNOMED: 279029001] Thyroid abnormality [ICD-10: E07.9], [ICD-9: 246.9], [SNOMED: 14304000] Anxiety [ICD-10: F41.9], [ICD-9: 300.00], [SNOMED: 48694002]

Plan

MONITOR CHRONIC HEALTH CONDITIONS-- SEE ATTACHED PATIENT ANXIOUS/ WORRIED IF BP HIGH AT FU WILL START ON BP MEDS POC/LABS/OTHER: SEE ATTACHED MEDS: PATIENT ASKING TO HOLD MEDS NOW UNTIL FOLLOW UP / TAKE OTC PAIN MEDS REFERRALS: MAMMOGRAM RETURN IN: RETURN IN 1-2 WK PATIENT ED: TAKE MEDS AS PRESCRIBED/BE COMPLIANT WITH TREATMENTS/HEALTHY LOW-FAT DIET/LOW NA+/EXERCISE/

NOTE: TREATMENT/PLAN DONE IN COLLABORATION WITH DR. ELIAS VANCE PROTOCOL.

4 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 1-614-555-0102 PAGE 06/35 58412 05/21/1965 03/07/2023 ARTHUR MILLER 51 yo Male 2:45 PM 789 Oak Ave, Chicago, IL 60601-1001 FollowUp (773) 555-9876 Dr. Elias Vance $0.00 Compassionate Care Alliance 0123456789 PT. BALANCE: $0.00

==OFFICE VISITS== ==IMMUNIZATIONS== ==DIAGNOSIS==

- NP Limited 99201 - Flu split 3yrs&above 90656 - Rhinitis J310
- NP Expanded 99202 - Flu Admin (care) G0008 - Abd pain RLQ / LLQ R103X
- NP Detailed 99203 - Pneumovax 90732 - Anemia D649
- NP Moderate 99204 - Pneumo Admin (care) G0009 - Obesity E6601
- NP Complex 99205 - TD 90714 - Low back pain M545 ==EST VISITS== - Hep A adult 90632 - Dermatitis/Eczema L309
- Est Limited 99211 - Hep B 1st shot 90746 - Headache G43011
- Est Expanded 99212 - Hep B 2nd shot 90743 - HTN I10
- Est Detailed 99213 - Hep B 3rd shot 90744 - Pneumonia J180
- Est Moderate 99214 - Varicella 250mg 90716 - Bronchitis, chronic / acute J42
- Est Complex 99215 - PPD 86580 - CHF I509 ==PREVENT MEDICINE== - Admin immun-single 90471 - COPD J449
- NP age 18-39 99385 - Admin imm-mult 90472 - Chest pain R072
- NP age 40-64 99386 ==PROCEDURES== - Cough R05
- NP age 65+ 99387 - Smoking Cessation 99407 - Impotence N529
- Est age 18-39 99395 - Remove impact cerumen 69210 - CVA I6789
- Est age 40-64 99396 - Nebulizer 94640 - Diabetes II controlled / brittle E119

- Est age 65+ 99397 - PFT 94010 - IDDM controlled / brittle E108 ==LABORATORY== - PFT pre/post 94060 - Rectal Bleeding K625
- Glucose 82962 RESUL` - EKG 93000 - Otitis Media H6690
- HgA1C - INJ major loc 20610 - OA-osteoarthritis loc M190XX
- Urine preg 81025 - INJ small loc 20600 - Sinusitis acute / chronic J0190
- Hemoccult 82270 ==HEDIS== - URI acute J060
- UA non automated 81002 - NOT ON BP MEDS - UTI N390
- Diabetic Eye Exam - Aspirin / Anticoag RX 4086F - Vaginitis candid / Bact / STD N760
- Rapid Flu A/B 87804 - ACE / ARB RX G8473 - Hypercholesterol E780
- Rapid Strep 87880 - Beta Blocker RX G8450 - Hyperlipidemia E784 ==INJECTION== - Chlam /Gono Screen 3511F - Annual exam 20000
- Rocephin 250 mg J0696 - No antibiotic Rx in Acute Bronchitis 4124F - Nutritional Counsel Z713
- Depo-provera 150 mg J1055 - Diabetic Eye 2026F - Activity Counsel Z7189
- Kenalog 10mg J3301 - NEG Eye Exam in Prior Yr 3072F - Medication Review 1160F
- B12 J3420 - HTN Panel Basic Panel - Medication List in Chart 1159F
- Lidocaine 10 mg J2001 - Functional Assessment 1170F - Medicare Wellness Exam, EST G0439
- Solumedrol 125 mg J2930 - Medicare Wellness Exam NP G0438
- Insulin to 50 units J1815
- Toradol 15 mg J1885
- Therapeutic Admin 96372

T-966 W-150.6 Thyroid Disease 24.31 BMI 128/70 BP lotes/Diagnosis: mt Paid Balance DR SIGNATURE Return Visit: Co-Pay WK MON 5 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 16145550102 PAGE 07/35 PI were for hollow up

motil COTE EFIS

@ Thyroid disorder than tho The Art в VHD Reples need fest Be coffee U

① (ICCHE) med 55% / ③ Thyroid Disease ③ BTSHA ?, ? Cause P/O Hyperthyroid X Checked - (T3 Tyfree + RMA TSH) ③ VHD Replace - sold out ⑤ HELP Surgery Feb 8 6 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 16145550102 PAGE 08/35

PATIENT FACILITY ENCOUNTER Arthur Miller Sterling Health Clinic Office Visit OB 05/21/1965 T (614) 555-0101 NOTE TYPE SOAP Note GE 58 yrs F (614) 555-0199 SEEN BY SARAH MILLER EX Male 456 Oak Avenue DATE 01/12/2023 RN ar987654

Columbus, OH 43215 AGE AT DOS 58 yrs Electronically signed by Dr. Sarah Miller PhD at 01/16/2023 02:46 pm

Chief complaint

Patient states he needs authorization or clearance for RT hip surgery

Vitals for this encounter

01/12/23 11:04 AM Height 66 in Weight 159.80 lb Temperature 97.60 °F BMI 25.79 Blood pressure 118/64 mmHg

Subjective

THE PATIENT IS A 58 yrs MALE THAT PRESENTED TO CLINIC TODAY AND STATES RIGHT HIP PAIN 10/10 OA SCHEDULED FOR HIP SX WITH DR ALISTAIR FINCH AT CENTRAL PLAINS MEDICAL CENTER DATE JAN 30, 2023. NEED SX CLEARANCE.

REVIEW OF SYSTEMS-- (ROS)

GENERAL HEALTH, EYES, EAR NOSE THROAT, CARDIOVASCULAR, RESPIRATORY, GASTROINTESTINAL, GENITOURINARY, MUSCULOSKELETAL, SKIN, NEUROLOGICAL, PSYCHIATRIC, ENDOCRINE, HEMATOLOGIC, ALLERGIC/IMMUNE SYSTEM

A BASIC REVIEW OF THE ABOVE SYSTEMS WERE NEGATIVE OTHER THAN SYMPTOMS THAT WERE INCLUDED IN THE ABOVE HISTORY OF PRESENT ILLNESS.

Objective

General: Alert and oriented x 3, no acute distress. Head: Normocephalic, no lesions. Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal. Ears: EAC's clear, TM's normal. Nose: Mucosa normal, no obstruction, no sinus tenderness. Throat: Clear, no exudates, no lesions. Neck: Supple, no masses, no thyromegaly, no bruits. Chest: Lungs clear, no rales, no rhonchi, no wheezes. Breast: DEFERRED

Heart: S1 S2, RRR, no murmurs, no rubs, no gallops. Abdomen: Soft, no tenderness, no masses, BS normal. GU: DEFERRED Back: Normal curvature, no tenderness. Extremities: RT HIP PAIN--FROM, no deformities, no edema, no erythema. Neuro: Physiological, no localizing findings. Skin: Normal, no rashes, no lesions noted.

Assessment

Diagnoses attached to this encounter:

Primary OA of right hip [ICD-10: M16.11], [ICD-9: 715.15], [SNOMED: 239862000]

Plan

MONITOR CHRONIC HEALTH CONDITIONS--SEE ATTACHED--CONT CURRENT TX POC TEST AND/OR TREATMENT: LAB TEST: LABS RESULTS: HEALTH ED: HEALTHY LOW-FAT DIET/LOW NA+/EXERCISE/LOSE WEIGHT MEDS/TAKE AS PRESCRIBED: MED REFILLS OTHER: REFERRALS: DR CARTER FOR SX CLEARANCE RETURN IN: 2 WKS

NOTE: TREATMENT/PLAN DONE IN COLLABORATION WITH DR. ELIAS VANCE PROTOCOL.

98765 05/21/1965 10/04/2022 ARTHUR MILLER 58 yo Male 2:30 PM 789 OAK AVE DR. ELIAS VANCE EstPtOV CHICAGO, IL 60601-1001 (773) 555-9876 $0.00 PT. BALANCE: Compassionate Care Alliance California 0123456789 $0.00

Column 1	Column 2	Column 3
==OFFICE VISITS==	==IMMUNIZATIONS==	==DIAGNOSIS==
_ NP Limited 99201	_ Flu split 3yrs&above 90656	_ Rhinitis J310
_ NP Expanded 99202	_ Flu Admin (care) G0008	

Column 1	Column 2	Column 3
		_ Abd pain RLQ / LLQ R103X
_ NP Detailed 99203	_ Pneumovax 90732	_ Anemia D649
_ NP Moderate 99204	_ Pneumo Admin (care) G0009	_ Obesity E6601
_ NP Complex 99205	_ TD 90714	_ Low back pain M545
==EST VISITS==	_ Hep A adult 90632	_ Dermatitis/Eczema L309
_ Est Limited 99211	_ Hep B 1st shot 90746	_ Headache G43011
_ Est Expanded 99212	_ Hep B 2nd shot 90743	_ HTN 110
_ Est Detailed 99213	_ Hep B 3rd shot 90744	_ Pneumonia J180
_ Est Moderate 99214	_ Varicella 250mg 90716	_ Bronchitis,chronic / acute J42
_ Est Complex 99215	_ PPD 86580	_ CHF 1509
==PREVENT MEDICINE==	_ Admin immun-single 90471	_ COPD J449
_ NP age 18-39 99385	_ Admin imm-mult 90472	_ Chest pain R072
_ NP age 40-64 99386	==PROCEDURES==	_ Cough R05
_ NP age 65+ 99387	_ Smoking Cessation 99407	_ Impotence N529
_ Est age 18-39 99395	_ Remove impact cerumen 69210	_ CVA 16789
_ Est age 40-64 99396	_ Nebulizer 94640	_ Diabetes II controlled / brittle E119
_ Est age 65+ 99397	_ PFT 94010	_ IDDM controlled / brittle E108
==LABORATORY==	_ PFT pre/post 94060	_ Rectal Bleeding K625
_ Glucose 82962	_ EKG 93000	_ Otitis Media H6690
_ HgA1C RESUL	_ INJ major loc__20610	_ OA-osteoarthritis loc_M190XX
_ Urine preg 81025	_ INJ small loc__20600	_ Sinusitis acute / chronic J0190
_ Hemoccult 82270	==HEDIS==	_ URI acute J060
_ UA non automated 81002	_ NOT ON BP MEDS	_ UTI N390
_ Diabetic Eye Exam	_ Aspirin / Anticoag RX 4086F	_ Vaginitis candid / Bact / STD N760
_ Rapid Flu A/B 87804	_ ACE / ARB RX G8473	_ Hypercholesterol E780

Column 1	Column 2	Column 3
_ Rapid Strep 87880	_ Beta Blocker RX G8450	_ Hyperlipidemia E784
==INJECTION==	_ Chlam /Gono Screen 3511F	_ Annual exam Z0000
_ Rocephin 250 mg J0696	_ No antibiotic Rx in Acute Bronchitis 4124F	_ Nutritional Counsel Z713
_ Depo-provera 150 mg J1055	_ Diabetic Eye 2026F	_ Activity Counsel Z7189
_ Kenalog 10mg J3301	_ NEG Eye Exam in Prior Yr 3072F	_ Medication Review 1160F
_ B12 J3420	_ HTN Panel__ Basic Panel	_ Medication List in Chart 1159F
_ Lidocaine 10 mg J2001	_ Functional Assessment 1170F	_ Medicare Wellness Exam EST G0439
_ Solumedrol 125 mg J2930	_ Medicare Wellness Exam NP G0438	
_ Insulin to 50 units J1815		
_ Toradol 15 mg J1885		
_ Therapeutic Admin 96372		

Temp 1980 BMI 25.15 BP 128/80 Notes/Diagnosis: UT: 155.8 (Handwritten Note) Amt Paid **_** *Balance* DR.SIGNATURE **__ (Handwritten Signature/Text) Return Visit: Co-Pay WK** MON __

08/11/2023 12:24 16145550102 PAGE 11/35 BL neck & Shoulder cologuard

① Neck pain à far tolle XYZ emoment arm ⑥ Rihip pein / Due suszy ⑥ Деталия зар 50 Cface

- 21 - (1)

AP ①

Corviaf porn ants-MOD MILLER

Xay Neel por ② Деталия A.M. ③ Hip pain 124 Fle Обтерам 10 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

PAGE 12/35 2:04 PM City Care Pharmacy 101 Elm Street Anywhere, CA 90210 10/04/2022

Rx Profile for: MILLER, ARTHUR

	Fill Date	Doctor	Drug	Sig	Next Fill / Exp Date	Qty	Refills	Rx Number	Pric
☐	09/28/2023	VANCE, ELIAS	BETAMET/ CLOTRIMAZOLE CREAM 1/0.05%	APPLY TO AFFECTED AREA TWICE A DAY	10/04/2023	45	0	789012	38.7
☐	09/20/2023	VANCE, ELIAS	METHYLPREDNISONE 4MG	USE AS DIRECTED	09/27/2023	21	0	789015	37.0
☐	09/05/2023	VANCE, ELIAS	ATORVASTATIN 20MG TABLET	TAKE ONE TABLET TWICE A DAY WITH FOOD	10/05/2023	60	0	789020	12.2
☐	12/08/2022	VANCE, ELIAS	CYCLOBENZAPRINE HCL 10MG TABLET ER	TAKE ONE TABLET TWICE DAILY	09/08/2023	60	0	60001	15.3
☐	12/08/2022	VANCE, ELIAS	ALPRAZOLAM 0.5MG TABLET	TAKE ONE TABLET TWICE DAILY, FOR 5 DAYS THEN AS NEEDED	09/08/2023	45	0	60005	15.3

1 Of 1 11 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 PAGE 13/35

08/11/2023 12:24 16145550102

58412 09/06/2022 ARTHUR MILLER 12:45 PM 789 OAK AVE. EstPtOV CHICAGO, IL 60601 50 yo Male DR. ELIAS VANCE $0.00 (773) 555-9876

COMPASSIONATE CARE ALLIANCE 0123456789-9876543210 PT. BALANCE: $0.00

==OFFICE VISITS== ==IMMUNIZATIONS== ==DIAGNOSIS== _ NP Limited 99201 _ Flu split 3yrs&above 90656 *Rhinitis J310 _ NP Expanded 99202 _ Flu Admin (care) G0008 _Abd pain RLQ / LLQ R103X _ NP Detailed 99203 _ Pneumovax 90732 _Anemia D649 _ NP Moderate 99204 _ Pneumo Admin (care) G0009 _Obesity E6601 _ NP Complex 99205 _ TD 90714 _Low back pain M545 ==EST VISITS== _ Hep A adult 90632 _Dermatitis/Eczema L309 _ Est Limited 99211 _ Hep B 1st shot 90746 _Headache G43011 _ Est Expanded 99212 2 _ Hep B 2nd shot 90743 _HTN 110 _ Est Detailed 99213 _ Hep B 3rd shot 90744 _Pneumonia J180 _ Est Moderate 99214 _ Varicella 250mg 90716 _Bronchitis, chronic / acute J42 _ Est Complex 99215 _ PPD 86580 _CHF 1509 ==PREVENT MEDICINE== _ Admin immun-single 90471 _COPD J449 _ NP age 18-39 99385 _ Admin imm-mult 90472 _Chest pain R072 _ NP age 40-64 99386 ==PROCEDURES== _Cough R05 _ NP age 65+ 99387 _ Smoking Cessation 99407 _Impotence N529 _ Est age 18-39 99395 _ Remove impact cerumen 69210 _CVA 16789 _ Est age 40-64 99396 _ Nebulizer 94640 _Diabetes II controlled / brittle E119 _ Est age 65+ 99397 _ PFT 94010 _IDDM controlled / brittle E108 ==LABORATORY== _ PFT pre/post 94060 _Rectal Bleeding K625 _ Glucose 82962 _ EKG 93000 _Otitis Media H6690 _ HgA1C*RESUL` _ INJ major loc***_20610 OA-osteoarthritis loc*M190XX _ Urine preg 81025 _ INJ small loc*20600 _Sinusitis acute / chronic J0190 _ Hemoccult 82270 ==HEDIS== _URI acute J060 _ UA non automated 81002 _ NOT ON BP MEDS _UTI N390 _ Diabetic Eye Exam _ Aspirin / Anticoag RX 4086F _Vaginitis candid / Bact / STD N760 _ Rapid Flu A/B 87804 _ ACE / ARB RX G8473 _Hypercholesterol E780 _ Rapid Strep 87880 _ Beta Blocker RX G8450 _Hyperlipidemia E784 ==INJECTION== _ Chlam /Gono Screen 3511F _ Annual exam Z0000 _ Rocephin 250 mg J0696 _ No antibiotic Rx in Acute Bronchitis 4124F _ Nutritional Counsel Z713 _ Depo-provera 150 mg J1055 _ Diabetic Eye 2026F _ Activity Counsel Z7189 _ Kenalog 10mg J3301 _ NEG Eye Exam in Prior Yr 3072F _ Medication Review 1160F _ B12 J3420 _ HTN Panel ___ Basic Panel ✓ Medication List in Chart 1159F _ Lidocaine 10 mg J2001 _ Functional Assessment 1170F _ Solumedrol 125 mg J2930 Medicare Wellness Exam NP G0438 Medicare Wellness

Exam EST G0439 _ Insulin to 50 units J1815 _ Toradol 15 mg J1885 _ Therapeutic Admin 96372

W: 152.8 T. 98.0 24.66 Notes/Diagnosis: BMI Amt Paid___ (1) BP 130/80 Balance DR SIGNATURE Return Visit: Co-Pay (3) Dermatity Wk MON 12 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 16145550102 PAGE 14/35

Brable - MRI ordered but did not RI no rele - Seeking therapy Rash fere arm - rash on arm. It fee = Depoprodate

- tender back
- tender R hip

① Rash/Dermatitis H/Aminter 2.1.7 BID → Lotion co out ② RI hip pai - H/o orthopedie V. Plan XRay R hips fr -

Back to top 13 of 34: 8F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/21/2021 - 07/06/2023

08/11/2023 12:24 13139938950 PAGE 15/35

58412 05/21/1965 12/09/2021 ARTHUR MILLER 49 yo 12:15 PM 789 Oak Ave Male EstPtOV Chicago, IL 60601 (773) 555-9876 ELIAS VANCE $0.00 Compassionate Care Alliance 0123456789 PT. BALANCE

--- $0.00 ---

| ==OFFICE VISITS== | ==IMMUNIZATIONS== | ==DIAGNOSIS== | | - NP Limited 99201 | - Flu split 3yrs&above 90656 | - Rhinitis J310 | | - NP Expanded 99202 | - Flu Admin (care) G0008 | - Abd pain RLQ / LLQ R103X | | - NP Detailed 99203 | - Pneumovax 90732 | - Anemia D649 | | - NP Moderate 99204 | - Pneumo Admin (care) G0009 | - Obesity E6601 | | - NP Complex 99205 | - TD 90714 | - Low back pain M545 | | ==EST VISITS== | - Hep A adult 90632 | - Dermatitis/Eczema L309 | | - Est Limited 99211 | - Hep B 1st shot 90746 | - Headache G43011 | | - Est Expanded 99212 | - Hep B 2nd shot 90743 | - HTN I10 | | - Est Detailed 99213 | - Hep B 3rd shot 90744 | - Pneumonia J180 | | - Est Moderate 99214 | - Varicella 250mg 90716 | - Bronchitis, chronic / acute J42 | | - Est Complex 99215 | - PPD 86580 | - CHF I509 | | ==PREVENT MEDICINE== | - Admin immun-single 90471 | - COPD J449 | | - NP age 18-39 99385 | - Admin imm-mult 90472 | - Chest pain R072 | | - NP age 40-64 99386 | ==PROCEDURES== | - Cough R05 | | - NP age 65+ 99387 | - Smoking Cessation 99407 | - Impotence N529 | | - Est age 18-39 99395 | - Remove impact cerumen 69210 | - CVA I6789 | | - Est age 40-64 99396 | -

Nebulizer 94640 | - Diabetes II controlled / brittle E119 | | - Est age 65+ 99397 | - PFT 94010 | - IDDM controlled / brittle E108 | | ==LABORATORY== | - PFT pre/post 94060 | - Rectal Bleeding K625 | | - Glucose 82962 | - EKG 93000 | - Otitis Media H6690 | | - HgA1C RESUL' | - INJ major loc 20610 | - OA-osteoarthritis loc M190XX | | - Urine, preg 81025 | - INJ small loc 20600 | - Sinusitis acute / chronic J0190 | | - Hemoccult 82270 | | - URI acute J060 | | - UA non automated 81002 | ==HEDIS== | - UTI N390 | | - Diabetic Eye Exam | - NOT ON BP MEDS | - Vaginitis candid / Bact / STD N76C | | - Rapid Flu A/B 87804 | - Aspirin / Anticoag RX 4086F | - Hypercholesterol E780 | | - Rapid Strep 87880 | - ACE / ARB RX G8473 | - Hyperlipidemia E784 | | ==INJECTION== | - Beta Blocker RX G8450 | - Annual exam Z0000 | | - Rocephin 250 mg J0696 | - Chlam /Gono Screen 3511F | - Nutritional Counsel Z713 | | - Depo-provera 150 mg J1055 | - No antibiotic Rx In Acute Bronchitis 4124F | - Activity Counsel 27189 | | - Kenalog 10mg J3301 | - Diabetic Eye 2026F | - Medication Review 1160F | | - B12 J3420 | - NEG Eye Exam in Prior Yr 3072F | - Medication List In Chart 1159F | | - Lidocaine 10 mg J2001 | - HTN Panel Basic Panel | | | - Solumedrol 125 mg J2930 | - Functional Assessment 1170F | | | - Insulin to 50 units J1815 | | | | - Toradol 15 mg J1885 | Medicare Wellness Exam NP G0438 | Medicare Wellness Exam EST G0439 | | - Therapeutic Admin 96372 | | |

W:169.0 C Lumbu Reduespect 25.6 BP 130/80 1:97.2 otes/Diagnosis: BMI

nt Paid Balance DR.SIGNATURE Co-Pay -Return Visit: WK MON

Back to top PAGE 16/35

No MVA c/o past 2012

- C/o pain Recently more pain + ↑ Symtoms Will need MRI Before

APQ

[Cervical Radiculopathy: Pain + arm MRI Neede (1) Xylocaine 500 mcg/ Remu 80> (2) Lumbar Radiculopathy: R leg pain H/o Pain Neuro Surgery MRI Lumbar Spine 15 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

08/11/2023 12:24 16145550198 PAGE 17/35

ATIENT FACILITY rthur Miller Sterling Health Clinic - South DOB 05/21/1965 T (614) 555-0303 GE 58 yrs F (614) 555-0399 EX Male 101 Maple Lane RN am987654 Grove City, OH 43123

Diagnoses

Current

(R20.0) Anesthesia of skin (M25.512) Pain in left shoulder (M16.11) Unilateral primary osteoarthritis, right hip (110) Essential (primary) hypertension (N63.10) Unspecified lump in the right breast, unspecified quadrant (M54.2) Cervicalgia (E07.9) Disorder of thyroid, unspecified (F41.9) Anxiety disorder, unspecified

ACUITY

Historical

No historical diagnoses

ACUITY

---

16 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

PAGE 18/35 12:33 PM

MILLER, ARTHUR 789 OAK AVE COLUMBUS, OH 43215 Phone:(773) 555-0101 Cell: () DOB: 05/21/1965 City Care Pharmacy 456 Oak Avenue Columbus, OH 43215 Phone:(555) 123-4567 Fax:(555) 123-4568 Fed. Id: NABP:9876543 NPI:1982691986

Profile From: 11/01/2022 thru 08/07/2023 08/07/2023

Fill Date	Rx Num	Qty	Drug	NDC	Doctor	Copay	Sig	Fill Number
02/22/2023	300197	42	HYDROCO/APAP 10-325MG	0048-0125-01	SHARMA, ANYA S	$0.00	TAKE ONE TABLET EVERY 4 HOURS AS NEEDED	0
05/17/2023	615685	4	VITAMIND S/ADJUNT	64186-0737-06	VANCE, ELIAS	$0.00	TAKE ONE	0

Fill Date	Rx Num	Qty	Drug	NDC	Doctor	Copay	Sig	Fill Number
							CAPSULE WEEKLY	
08/07/2023	635584	30	DAILY-VITE	00536-3547-10	VANCE, ELIAS	$0.00	TAKE ONE TABLET DAILY	0
				$0.00				

08/11/2023 12:24 16145550102

Pharmacist ___ 1 Of 1 17 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 6145550198 PAGE 19/35

[SecurePortal Logo placeholder] Main Menu Logout Help

Exam Request Verification: Detail

[Upload Clinical Document] [Print Fax Cover Sheet] [Withdraw Request]

Member	Referring Physician	Rendering Provider
Name: ARTHUR M MILLER	Name: Dr. Elias Vance	Name: CENTRAL PLAINS MEDICAL CENTER
Gender: Male	Address: 456 Oak Avenue, Columbus, OH 43215	Address: 789 Oak Avenue, Omaha NE 68102
Date of Birth: 05/21/1965	Phone: (614) 555-0101	Phone: (402) 555-1213
Member ID: 0123456789-9876543210	Tax ID: 471234567	Tax ID: 987654321
Health Plan: 29778 Compassionate Care Alliance CA Health Plan HMO	UPIN:	
Specialty: Family Medicine		

Exam	Request ID/ Tracking	Radiology
		Date of Service: 7/21/2021 Change

Exam	Request ID/ Tracking	Radiology
Case Description: Lumbar Spine MRI	Request ID: Not Available	
Request Date: 07/19/2021 10:10 AM	Tracking: 98765432109	Expedited: No
Entry Method: SecurePortal	Status: In Review	CPT4: 72148 Billable Codes
ICD10: M54.2, M54.5	Validity Dates: [Not Applicable]	Clinical Recvd: 7/19/2021 - Clinical information received via fax or upload
Contact Name: Sarah Chen (Referring Provider)		

Initial Determination Date: NOT COMPLETED Final Determination Date: NOT COMPLETED

Medical Necessity Evaluation

Question	Answer
Why is this study being ordered?	This study is being ordered for Other
What was the date of the initial onset?	Not sure on onset of the pain. Patient was seen in the on 6/29/2021. With Complain of pain with radiation. Also note patient states he was in an auto accident in 2012.
Has there been any treatment or conservative therapy?	There has been treatment or conservative therapy.
What treatment or conservative therapy was given?	Patient previously had physical therapy
What are the primary symptoms?	Pain and stiffness of the neck with radiation to the arm and had. C5-C6. Patient also complain of low back pain - Lumber ridiculopathy
Please provide additional clinical reasons for this study.	No other info

Current Status

Date	Status
07/19/2021 10:15AM	Your clinical documentation has been received and is being reviewed by our clinical staff. You will be notifed of the determination.
07/19/2021 10:15AM	This request is being reviewed by our physicians
07/19/2021 10:15AM	Your clinical documentation has been received and is being reviewed by our clinical staff. You will be notifed of the determination.

https://www.secureportal.net/SecurePortal/Verification/Detail.aspx?a=ABC123XYZ456&d=789&m=&appeal=

Back to top 1/2 18 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 PAGE 20/35

08/11/2023 12:24 1-614-555-0102

Request Verification Details 07/19/2021 10:10AM Please fex or upload the clinical documentation requested In the fax or emall we sent to you.

There are no received faxes available for this request.

Document Uploaded Monday, July 19, 2021 Document Uploaded Monday, July 19, 2021

Click here to see letters sent related to this case

Please be advised that all data was current as of Monday, July 19, 2021 at 10:19 AM MST

[Submit to Research Criteria]

---

https://portal.aurorahealth.com/Auth/Details.aspx?id=XYZ789ABC&ref=456&type=verify 2/2 Back to top 19 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 1-614-555-0102 PAGE 21/35

Fax

TO	**Imaging Services - Script**	**SPECIALTY**	**Diagnostic Radiology**
PHONE	(727) 555-9876	FAX	(727) 555-1234
FROM	Dr. Elias Vance MD at Sterling Health Clinic - Central	SPECIALTY	Internal Medicine
PHONE	(614) 555-0101	FAX	(614) 555-0199
SUBJECT	Patient Referral	TIME	01:04:37 PM
DATE	07/06/2023		

Dr. Elias Vance MD sent you this referral using Compassionate Care Connect's System. To retrieve this referral instantly online, sign up for a Compassionate Care Connect account today.

compassionate care connect

Compassionate Care Connect, the #1 cloud based client management system for doctors and patients

---

Retrieve referral online at: https://secure.compassionatecareconnect.com/referral/ABCDEF1 Your referral access code is ABCDEF1

Expires in 14 days and will stay active for 30 days after retrieval

PATIENT		STERLING HEALTH CLINIC
ARTHUR MILLER H N/A		T 6145550101
DOB 05/21/1965	M (773) 555-9876	F 6145550199
AGE 58 yrs	W N/A	456 OAK AVENUE
SEX Male	E N/A	COLUMBUS, OH 43215
PRN am987654	789 OAK AVE	
	CHICAGO, IL 60601	

Referrals/Response Letter

To: Aurora Medical Plaza - Script From: Dr. Elias Vance, ABFM Sent: 07/06/2023 13:04:37 Subject: Patient Referral Regarding: arthur miller

AURORA MEDICAL PLAZA 789 OAK AVENUE CLEARWATER, FL 33755 (727) 555-9876

We are referring Arthur Miller to you for evaluation and treatment.

DX: Lump on/ under right areola

PLEASE NOTE NO LOTION, POWDER, CREAM ON UPPER BODY PLEASE BRING THIS SLIP, ID AND INSURANCE CARD TO APPOINTMENT

Sincerely,

Dr. Elias Vance M.D.

Insurance

PRIMARY PAYER		
NAME	Compassionate Care Alliance	ADDRESS
PLAN	Other - Compassionate Care Alliance	555 SERENITY LANE, SUITE 100
GROUP ID		Harmony Creek, CA 90210
INSURANCE ID	0123456789	

Fax

TO	**Imaging Services - Script**	**SPECIALTY**	**Diagnostic Radiology**
PHONE	(727) 555-9876	FAX	(727) 555-1234
FROM	Dr. Elias Vance, MRCP at Sterling Health Clinic	SPECIALTY	Internal Medicine
PHONE	(614) 555-0101	FAX	(614) 555-0199
SUBJECT	Patient Referral	TIME	01:01:52 PM
DATE	07/06/2023		

Dr. Elias Vance, MRCP sent you this referral using Compassionate Care Connect's Client Management System. To retrieve this referral instantly online, sign up for a Compassionate Care Connect account today.

compassionate care connect Compassionate Care Connect, the leading client management system for providers and clients

---

> Retrieve referral online at: secure.compassionatecareconnect.org/client-portal/#/referral/TD96Z3W Your referral access code is TD96Z3W

Expires in 14 days and will stay active for 30 days after retrieval

---

PATIENT H N/A STERLING HEALTH CLINIC - CENTRAL ARTHUR MILLER M (773) 555-9876 T 6145550101 DOB 05/21/1965 W N/A F 6145550198 AGE 58 yrs E N/A 456 OAK AVENUE SEX Male 789 OAK AVE COLUMBUS, OH 43215

PRN ff201687 CHICAGO, IL 60601-1001

Referrals/Response Letter

To: Aurora Medical Plaza - Script From: Dr. Elias Vance MD, MRCP Sent: 07/06/2023 13:01:52 Subject: Patient Referral Regarding: arthur miller

We are referring Arthur Miller to you for evaluation and treatment.

Dx: Lump on/ under right nipple

Sincerely,

Dr. Elias Vance M.D.

Insurance

PRIMARY PAYER

NAME Compassionate Care Alliance ADDRESS 555 Serenity Lane, Suite 100 PLAN Other - Compassionate Care Alliance Harmony Creek, CA 90210 GROUP ID INSURANCE ID 0123456789

Referral electronically submitted by Dr. Elias Vance MD, MRCP 07/06/2023 01:01PM

Date: 7-6-23

Patient Name: Arthur Miller

Date of Birth:

Tech: JR

Glucose (Fingerstick):

Urine HCG Results: Positive Negative

Injection:

NDC:

Lot:

Exp:

HBA1C Results Siemens Microalbumin Results Clinitek Status® Serial Number: 201262 Patient: Arthur Miller Multistix® 10 SG Test date 07-06-2023 Time 5:29PM Operator JR Test number 7922 Color Not Entered Clarity Not Entered

- GLU Negative
- BIL Negative
- KET Negative
- SG 1.015
- BLO Negative
- PH 7.5
- PRO Negative
- URO 0.2 E.U./dL
- NIT Negative

- LEU Negative

08/11/2023 12:24 16145550102 2/3/2023 14:15:16 PST PAGE 26/35 Page 1 of 1 Dr. Emily Carter, MD Maplewood Medical Center, 789 Oak Ave, Suite 201 Springfield, IL 62704 Phone (217) 555-1234 Fax (217) 555-1235 ECHOCARDIOGRAM AND CARDIAC DOPPLER REPORT PATIENT NAME: ARTHUR MILLER ORDERING PHYSICIAN: DATE OF TEST: 01/20/23 DR. EMILY CARTER, MD PRIMARY PHYSICIAN: AGE/DOB: 05/21/1965 HEIGHT: 5'7" SONOGRAPHER: INDICATION: Shortness of breath. ALEX CHEN WEIGHT: 156 lbs. M-MODE, 2-D, AND DOPPLER STUDY WITH PULSE WAVE, CONTINUOUS WAVE AND COLOR MAPPING:

		Normal		**Normal**
Aortic Root:	26 (20-37 mms)	LV-Diastole:	56	(37-56 mms)
LA Dimension:	36 (19-40 mms)	LV-Systole:	40	(<40 mms)
Aortic Valve:		% of FS:	28%	(34% & above)
Septal Wall Thickness:	08 (6-14 mms)	EF:	55%	(55-70%)
Posterior Wall Thickness:	09 (6-14 mms)			

Left Atrium: Normal size. Right Atrium: Normal size. Left Ventricle: Normal size with normal wall thickness and normal segmental wall motion. Right Ventricle: Normal size and systolic function. Aortic Root: Normal Mitral Valve: Structurally normal. Tricuspid Valve: Structurally normal. Aortic Valve: Structurally normal. Pulmonary Valve: Structurally normal. Pericardium: No pericardial effusion. Great Vessels: Normal inferior vena cava and abdominal aorta. Miscellaneous: Shortness of breath.

DOPPLER: Trivial mitral regurgitation. Normal antegrade flow across aortic and pulmonary valves. DT: 198 ms.

CONCLUSION:

1. Normal left ventricle size with normal wall thickness and normal systolic function. Estimated ejection fraction 55%.
2. Normal diastolic function.
3. Trivial mitral regurgitation. 25 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

08/11/2023 12:24 16145550102 PAGE 27/35

GENESIS DIAGNOSTICS 789 Oak Avenue, Suite B PH: 800-111-2222 Fax: 800-111-2222

To: From: Dr. Elias Vance Genesis Diagnostics Fax: 800-111-2222 Sterling Health Clinic - Central

---

Sent 12-05-2022 7:14 AM 2 page(s) (including cover)

Subject: Action Requested Cologuard Order: 31784850

If you have any questions about this communication, please call our Customer Care Center at available 24 hours a day, seven days a week.

Thank you,

To: From: Genesis Diagnostics Genesis Diagnostics Dr. Elias Vance 6145550198

Sterling Health Clinic - Central 800-111-2222 (Signature) (including cover)

Genesis Diagnostics 789 Oak Avenue, Suite B, Rivertown, CA 90210 TEL: 800-111-2222 FAX: 800-111-2222 www.genesisdiagnostics.com

This information is intended... disclosure, copying, distribution or use of the contents is prohibited. If you have received this communication in error... please notify Genesis Diagnostics at 1-800-111-2222. 26 of 34: 8F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/21/2021 - 07/06/2023 08/11/2023 12:24 16145550102 PAGE 28/35

GENESIS DIAGNOSTICS

789 Oak Avenue, Suite B, Rivertown, CA 90210 800-111-2222

Action Requested

(Illegible introductory text about action) If you have any questions about this communication, please call our 24/7 Customer Care Center at 800-111-2222

Date Order Received by Labs: 10/05/2022	
Provider Name:	Dr. Elias Vance
Patient Name:	Arthur Miller 98-7654
Patient DOB:	05/21/1965

Thank you for your help!

---

12 05-207 (Partial date/timestamp)

GENESIS DIAGNOSTICS

789 Oak Avenue, Suite B, Rivertown, CA 90210 800-111-2222

Action Requested

(Similar illegible introductory text) If you have any questions about this communication, please call our 24/7 Customer Care Center at 800-111-2222

Date Order Received by Labs: (Illegible)	
Provider Name:	GENESIS DIAGNOSTICS
Patient Name:	(Illegible) (Illegible)
Patient DOB:	(Illegible)

(Illegible footer, likely www.genesisdiagnostics.net or similar)

(Partial date/timestamp)

GENESIS DIAGNOSTICS

(Address and contact information appear similar)

Action Requested

(Similar illegible introductory text) If you have any questions about this communication, please call our 24/7 Customer Care Center at 800-111-2222

Date Order Received by Labs: (Illegible)

Provider Name:	(Illegible)
Patient Name:	(Illegible) (Illegible)
Patient DOB:	(Illegible)

(Illegible footer, likely www.genesisdiagnostics.net or similar) 08/11/2023 12:24 16145550102 PAGE 29/35

Sterling Health Clinic DEA #__ Lic. #_

☐ DR. ELIAS VANCE ☐ ELEANOR VANCE, D.O. ☐ DR. ANYA SHARMA, M.D. 456 Oak Avenue. - Columbus, OH 43215 P: (614) 555-0101 F: (614) 555-0199 789 Pine Street - Worthington, OH 43085 P: (614) 555-0202 F: (614) 555-0299 101 Maple Lane - Grove City, OH 43123 P: (614) 555-0303 F: (614) 555-0399

Name: Arthur Miller Date: 10/4/2022 Address: DOB: 05/21/1965

R X-ray of neck Dx: Cervical pain

☐ Label Refill: 0 - 1 - 2 - 3 - 4 - PRN

Dr. Elias Vance

_ M.D. PAGE 30/35 08/11/2023 12:24 13139938950

01/19/2022 12:44:58 PM -0500 FAXCOM PAGE 2 OF 5

Compassionate Care Alliance
800-777-8888

555 Serenity Lane, Suite 100 TTY 711

Harmony Creek, CA 90210 www.gentlehands.org

Arthur Miller 789 Oak Ave Chicago, IL 60601-1001 01/19/2022

Notice of Receipt of Internal Appeal/Grievance
Gentle Hands Services

Important: Read this notice carefully. If you need help, you can call one of the numbers listed on the next

page under "Get Help & More Information."

Mailing Date: 01/19/2022 Member/Beneficiary ID: 0123456789

Name: Arthur Miller Member Date of Birth: 05/21/1965

This Notice is in response to the Internal Appeal or Grievance that we got on 01/18/2022.

[] You Filed A Grievance

We got your grievance on about . We take your concerns seriously. Thank you for taking the time to bring this to our attention.

WHAT THIS MEANS

We will review your grievance by . A letter will be mailed to you after we

complete our review telling you what we found and what (if any) action we will take, or have taken.

CA01 CA 29 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

08/11/2023 12:24 16145550102 PAGE 31/35 01/19/2022 12:44:58 PM -0500 FAXCOM PAGE 3 OF 5

Compassionate Care
Alliance .....

☑ You Filed An Internal Appeal

We got your request for an Internal Appeal on 01/18/2022. You are appealing our decision to deny a kind of picture (Magnetic Resonance Imaging (MRI)) of your low back without dye (contrast) at Willow Creek Health System on 01/04/2022.

WHAT THIS MEANS

A decision on this Internal Appeal will be made by 02/17/2022. A letter will be mailed to you telling you what our decision is and why we made that decision.

We may call you for more information or if we have more questions. If you have any questions or want to give us more information please call 800-777-8888.

FOR BOTH GRIEVANCES AND APPEALS

If you want someone to represent you

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing. We will let you know if we will need any other information from your representative. If we do not get your signed request or the information that is needed, we will not be able to complete your review.

Get Help & More Information

Call Compassionate Care Alliance if you need help or more information about our decision and the Internal Appeal process toll-free at: 800-777-8888 (TTY: 711), Monday - Friday 8 a.m. to 6 p.m. You can also visit our website at www.gentlehands.org Call California Department of Social Services (CDSS) Beneficiary Help Line toll-free at: 1-800-952-5253, TTY users call 1-800-952-8349

---

compassionatecarealliance

Compassionate Care Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Compassionate Care Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Compassionate Care Alliance:

Provides free aids and services to people with disabilities to communicate effectively with us, such as: o Qualified sign language interpreters o Written information in other formats (large print, audio, accessible electronic formats, other formats) Provides free language services to people whose primary language is not English, such as: o Qualified interpreters o Information written in other languages

If you need these services, contact Compassionate Care Alliance's Grievance Coordinator.

If you believe that Compassionate Care Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Compassionate Care Alliance's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email, If you need help filing a grievance, Compassionate Care Alliance's Grievance Coordinator is available to help you.

Mail: Compassionate Care Alliance Attn: Grievance Coordinator P.O. Box 789 Harmony Creek, CA 90211 Telephone: 800-777-8888 (TTY users should call 711) Fax: 310-999-0001 Email: info@gentlehands.org

You can also file a civil rights complaint with the Community Outreach and Support Services Alliance, electronically through the Community Outreach Complaint Portal, available at https://portal.communitysupport.org/complaint, or by mail or phone at:

Community Outreach and Support Services Alliance 456 Oak Avenue, Suite 300 Anytown, CA 90210

(555) 123-4567, (555) 987-6543 (TDD)

Complaint forms are available at http://www.communitysupport.org/file-complaint. 31 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023 08/11/2023 12:24 16145550102 PAGE 33/35 01/19/2022 12:44:58 PM -0500 FAXCOM

Compassionate Care Alliance

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-777-8888 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-777-8888 (رقم هاتف الصم والبكم: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-777-8888 (TTY: 711).

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita kayo ng Tagalog, maaari kayong gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-777-8888 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 800-777-8888 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-777-8888 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-777-8888 (TTY: 711)로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-777-8888 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-777-8888 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-777-8888 (TTY: 711).

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-777-8888 (TTY: 711).

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 800-777-8888 (TTY: 711)।

日本語 (Japanese): 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。 800-777-8888 (TTY: 711) まで、お電話にてご連絡ください。

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-777-8888 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ܣܘܼܪܲܝܬ (Assyrian): ܙܘܼܗܵܪܵܐ: ܐܸܢ ܐܲܚܬܘܿܢ ܟܹܐ ܗܵܡܙܸܡܝܼܬܘܿܢ ܠܸܫܵܢܵܐ ܐܵܬܘܿܪܵܝܵܐ، ܟܡܵܨܝܼܬܘܿܢ
ܕܡܲܦܠܚܝܼܬܘܿܢ ܚܸܠܡܬܵܐ ܕܗܲܝܵܪܬܵܐ ܒܠܸܫܵܢܵܐ ܠܸܫܵܢܵܐ ܡܲܓܵܢܵܐ. ܩܪܘܼܐ ܠܛܹܠܝܼܦܘܿܢ:
800-777-8888 (TTY: 711)

MA32 MI 32 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

08/11/2023 12:24 1-614-555-0102 PAGE 34/35

01/19/2022 12:44:58 PM -0500 FAXCOM PAGE 1 OF 5

W Compassionate Care Alliance

FACSIMILE

To: Dr. Elias Vance Company: Fax Number: (310) 555-9012 Phone Number:

From: Compassionate Care Alliance Fax Number: 310-999-0001 Phone Number:

Total Pages: 5 Date: January 19, 2022 Subject: Appeal Acknowledgement Letter

Memo:

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the Federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule (45 C.F.R Part 160; subparts A abd E of Part 164). This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone at 310-999-0000 to arrange the return or destruction of the information and all copies.

www.gentlehands.org

08/11/2023 12:24 16145550102

555-123-4567 789 ELM ST STE 925

Sterling Health Clinic ☐ Dr. Elias Vance ☐ Eleanor Vance, D.O. ☐ Dr. Anya Sharma, M.D. 456 Oak Avenue, Columbus, OH 43215 789 Pine Street, Worthington, OH 43085 101 Maple Lane, Grove City, OH 43123

P: (614) 555-0101 F: (614) 555-0199 P: (614) 555-0202 F: (614) 555-0299 P: (614) 555-0303 F: (614) 555-0399

DEA # _ *Lic. #* _

Name: Arthur Miller Address: __ Date: 12/9/21

R neuro surgery

DX: Lumbar Ridu dopaty

☐ Label Refill - 0 - 1 - 2 - 3 - 4 - PRN _, M.D.

614-555-0150

Sterling Health Clinic ☐ Dr. Elias Vance ☐ Eleanor Vance, D.O. ☐ Dr. Anya Sharma, M.D. 456 Oak Avenue, Columbus, OH 43215 789 Pine Street, Worthington, OH 43085 101 Maple Lane, Grove City, OH 43123

P: (614) 555-0101 F: (614) 555-0199 P: (614) 555-0202 F: (614) 555-0299 P: (614) 555-0303 F: (614) 555-0399

DEA # _ *Lic.* # _

Name: Arthur Miller Address: __ Date: 12/9/21

R MRI Without contrast of Lumbar spine

DX: Lumbar pain L-5

☐ Label Refill - 0 - 1 - 2 - 3 - 4 - PRN _, M.D. 34 of 34: 8F: Office Treatment Records - OFFCREC Src: STERLING HEALTH CLINIC 07/21/2021 - 07/06/2023

08/11/2023 12:24 16145550102 PAGE 02/35 06.28.2023 10:30:07 National Benefits Agency HelpDesk#:8775552000 Page 2/7

State of California Department of Social Services PO Box 4020 Sacramento, CA 95814

REQUESTED FOR: NBA; DISABILITY EVALUATION UNIT CLAIM

PROVIDER: STERLING HEALTH CLINIC ATTN:ANNA 456 OAK AVENUE COLUMBUS, OH 43215 Date: June 28, 2023

Co
Pa

CL
DI
DO
CA
Fi

TO RETURN: THIS INVOICE/COVER SHEET MUST BE INCLUDED AS THE 1ST PAGE (FOLLOWED BY RECORDS) VIA ONE OF THESE METHODS:

Mail to: California Department of Social Services Disability Determination Services For National Benefits Agency P.O. Box 5000 New Town, KY 40701-0001

Submit Electronically via your secure account with National Benefits Agency Secure Transmissions. For more information or to register, call the Help Desk at phone #1-866-555-5000.

Fax to #: (877) 555-4001 Date: __ # of Pages: __ Sending fax #: 6145550198

INVOICE DETAILS: To be paid, you must have a registered Payment Profile within the State of California's ALPHA Program. If the payment information below is blank, incorrect, or does not match what is registered in ALPHA, provide the correct Information on this page AND contact ALPHA via phone #916-555-1234 or online at www.california.gov/alphass to register/update your vendor information.

IF YOU FAIL TO DO THIS, WE CANNOT PAY YOU

[ ] RECORDS SENT [ ] NO CHARGE [ ] NO RECORDS AMOUNT BILLED: $15.00

VEND-INV ID #: 20240701987654 ALPHA VENDOR/ADDRESS ID: VA9876543/010 If incorrect, update payment information here: PAYEE: ALPHA Vendor & Address ID: __ STERLING HEALTH CLINIC Tax ID #: __ 456 OAK AVENUE Vendor Name: __ COLUMBUS, OH 43215 Vendor Address: __ Phone: (614) 555-0101

PAYMENT GUIDELINES: Vendor Telephone: __

- This invoice must be submitted to the issuing agency within 90 days of the date of this letter to receive reimbursement for the records. DO NOT STAMP OR PRINT WITHIN THIS BOX
- We will-pay up to $15.00 for medical records.
- Federal regulations prohibit prepayment, however, we do pay promptly upon recelpt of requested records. ROID:CASV9876543 SITE:C11 DV:2 SSN:\\\\\ DOCTYPE:0002 RF:E CS:888f

1 of 3: 9F: HIT MER - HITMER Src: Unity Care Clinic #2 02/26/2024

Health Information Technology (HIT) Medical Report

SSA Disclaimer: The following displays data transmitted to the SSA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. sample).

Summary of episode note Continuity of Care Document Received From: Unity Care Clinic

Creation Date:	**Date Range Requested:**	**Type of Request:**
02/26/2024	02/10/2023 - 02/26/2024	User Triggered

| Arthur Miller | DOB: 05/21/1965 | Gender: Male | | SSN: 456-12-7890 | | |

Partner Medical Record Demographics:

Name: Arthur Miller (Legal) DOB: 05/21/1965 Gender: Male

Back to top 2 of 3: ABC: XYZ REC - XYZREC Src: Unity Care Clinic #2 02/26/2024

Table of Contents

Section Name Page Healthcare Providers [PROV LIST].....3 Medication Information [MEDS].....3 Plan of Care [CARE PLAN].....3 3 of 3: 9F: HIT MER - HITMER Src: Unity Care Clinic #2 03/15/2023

PROV LIST Healthcare Providers Unity Care Clinic (01/01/2018 - No Date Available)

Provider Name	**Address Telecom**	**MRN**
Dr. Eleanor Vance, MD	tel:+1-585-241-0987, fax: +1-585-365-7890	98765432

MEDS Medication Information

Narrative Text No known medications

CARE PLAN Plan of Care

Narrative Text Not on file

Back to top

1 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023

LAW OFFICES LEGAL ADVOCATES FOR THE DISABLED

WALKER, THOMPSON & PETERSON, P.C.

1789 Main Street • Suite 201 • Anytown, CA 90210 Phone (310) 555-0189 • Fax (310) 555-0190

Eleanor R. Walker Thomas J. Anderson Robert L. Clark Elizabeth G. Foster William B. Davis James H. Green Charles F. Evans George I. Harris Wesley J. Lamey (Of Counsel)

Case #: 11-98765

RE: Arthur Miller SSN: 456-12-7890 Cityville Appeals Office

Facility name: Sterling Health Clinic

Dated: 7/6/2023 to 7/7/2023

2 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023

04/18/2024 13:23 16145550102 PAGE 02/16 4/18/24, 12:57 PM Encounter - Office Visit Date of service: 07/06/23 Patient: arthur miller DOB: 05/21/1965 PRN: am1965789

PATIENT | FACILITY | ENCOUNTER arthur miller | Sterling Health Clinic - Central | Office Visit DOB | 05/21/1965 | T (614) 555-0101 | NOTE TYPE SOAP Note AGE | 58 yrs | F (614) 555-0199 | SEEN BY Robert Chen PA-C SEX | Male | 456 Oak Avenue | DATE 07/06/2023 PRN | am1965789 | Columbus, OH 43215 | AGE AT DOS 57 yrs | | | | Electronically signed by Robert Chen PA-C at | | | | 07/10/2023 02:03 pm

Chief complaint

Patient states he needs to have his neck checked, has a knot on/under his nipple

Vitals for this encounter

	07/06/23
	11:38 AM
Height	66 in
Weight	159.6 lb
Temperature	97.80 °F
BMI	25.76
Blood pressure	160/80 mmHg

Diagnoses Was diagnosis reconciliation completed? No selection made

Current	ACUITY	START	STOP
(R20.0) Anesthesia of skin			
(M25.512) Pain in left shoulder			
(M16.11) Unilateral primary osteoarthritis, right hip			
(I10) Essential (primary) hypertension			
(N63.10) Unspecified lump in the right breast, unspecified quadrant			
(M54.2) Cervicalgia			
(E07.9) Disorder of thyroid, unspecified			
(F41.9) Anxiety disorder, unspecified			

Historical	ACUITY	START	STOP

No historical diagnoses

Medications Was medication reconciliation completed? No selection made

Active	SIG	START/ STOP	ASSOCIATED DX

No active medications recorded

https://secure.compassionatecare.net/ehr/index.html#/CHC/clients/abc123def-4567-8901-greg-hijk987654/session/xyz789uvw-0123-4567-lmn-opqrs... 1/3 Back to top 3 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023 04/18/2024 13:23 16145550102 PAGE 03/16 Encounter - Office Visit Date of service: 07/06/23 Patient: arthur miller DOB: 05/21/1965 PRN: am650521

Subjective

THE PATIENT IS A 51 yrs MALE THAT PRESENTED TO CLINIC TODAY AND STATES RT BREAST HAS LUMP IN NIPPLE MILD TENDERNESS X 1 MONTH. LEFT NECK PAIN X 10 YRS INTERMITTENTLY DUE TO CAR ACCIDENT 2012.

OTHER WISE FEELING WELL. REPORTS NOT ON ANY MEDS

REVIEW OF SYSTEMS- (ROS)

GENERAL HEALTH, EYES, EAR NOSE THROAT, CARDIOVASCULAR, RESPIRATORY, GASTROINTESTIONAL, GENITOURINARY, MUSCULOSKELETAL, SKIN, NEUROLOGICAL, PSYCHIATRIC, ENDOCRINE, HEMATOLOGIC, ALLERGIC/IMMUNE SYSTEM

A BASIC REVIEW OF THE ABOVE SYSTEMS WERE NEGATIVE OTHER THAN SYMPTOMS THAT WERE INCLUDED IN THE ABOVE HISTORY OF PRESENT ILLNESS.

Objective

General: Alert and oriented x 3, no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal.

Ears: EAC's clear, TM's normal.

Nose: Mucosa normal, no obstruction, no sinus tenderness.

Throat: Clear, no exudates, no lesions.

Neck: L POST NECK MILD TENDERNESS ON PALPATION OF C SPINE AREA APPROX AT C 7 AREA Supple, no masses, no thyromegaly, no bruits.

Chest: Lungs clear, no rales, no rhonchi, no wheezes.

Breast: RT BREAST SMALL MOBILE LUMP WITHIN NIPPLE MILD TENDERNESS

Heart: S1 S2, RRR, no murmurs, no rubs, no gallops,

Abdomen: Soft, no tenderness, no masses, BS normal.

GU: DEFERRED

Back: Normal curvature, no tendemess.

Extremities: FROM, no deformities, no edema, no erythema.

Neuro: Physiological, no localizing findings.

Skin: Normal, no rashes, no lesions noted.

Assessment

Diagnoses attached to this encounter:

- HTN [ICD-10: I10], [ICD-9: 401.9], [SNOMED: 38341003]
- Lump in the rt breast [ICD-10: N63.10], [ICD-9: 611.72], [SNOMED: 12240221000119106]
- C spine pain [ICD-10: M54.2], [ICD-9: 723.1], [SNOMED: 279029001]

Back to top 4 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023

Thyroid abnormallity [ICD-10: E07.9]. [ICD-9: 246.9], [SNOMED: 14304000]

Anxiety [ICD-10: F41.9], [ICD-9: 300.00], [SNOMED: 48694002]

Plan

MONITOR CHRONIC HEALTH CONDITIONS— SEE ATTACHED PATIENT ANXIOUS/ WORRIED IF BP HIGH AT FU WILL START ON BP MEDS POC/LABS/OTHER: SEE ATTACHED MEDS: PATIENT ASKING TO HOLD MEDS NOW UNTIL FOLLOW UP / TAKE OTC PAIN MEDS REFERRALS: MAMMOGRAM RETURN IN: RETURN IN 1-2 WK PATIENT ED: TAKE MEDS AS PRESCRIBED/BE COMPLIANT WITH TREATMENTS/HEALTHY LOW-FAT DIET/ LOW NA+/EXERCISE/

NOTE: TREATMENT/PLAN DONE IN COLLABORATION WITH DR. ELIAS VANCE PROTOCOL.

Compassionate Care Connect 5 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023 PAGE 05/16 04/18/2024 13:23 4/18/24, 12:59 PM 16145550102 miller, arthur 05/21/1965 Order #SC123456A

Lab Results for miller, arthur (Male, 05/21/1965)

Compassionate Care Connect

Laboratory

Name: Community Assistance Program (CAP)

Patient information

Patient ID: am987654 Mobile: (773) 555-9876 Address: 789 oak ave Chicago, IL 60601

Attachments

attachment1

Comment:

1 week follow Dr Vance review

LIPID PANEL, STANDARD

Observations	Result	Reference / UoM	Date/ Status
CHOLESTEROL, TOTAL [1]	167	<200 mg/dL	07/07/2023 02:37 pm
HDL CHOLESTEROL [1]	46	> OR = 40 mg/dL	07/07/2023 02:37 pm
TRIGLYCERIDES [1]	● 161	<150 mg/dL Above high normal	07/07/2023 02:37 pm
LDL-CHOLESTEROL [1]	95	mg/dL (calc)	07/07/2023 02:37 pm
Vendor note: Reference range: <100		Desirable range <100 mg/dL for primary prevention; <70 mg/dL for patients with CHD or diabetic patients with > or = 2 CHD risk factors. LDL-C is now calculated using the Martin-Hopkins calculation, which is a validated novel method providing better accuracy than the Friedewald equation in the	

Observations	Result	Reference / UoM	Date/ Status
		estimation of LDL-C. Martin SS et al. JAMA. 2013;310(19): 2061-2068 (http://education.CommunityAssistanceProgram.com/faq/FAQ164 (http://education.CommunityAssistanceProgram.com/faq/FAQ164))	
CHOL/HDLC RATIO [1]	3.6	<5.0 (calc)	07/07/2023 02:37 pm
NON HDL CHOLESTEROL [1]	121	<130 mg/dL (calc)	07/07/2023 02:37 pm
Vendor note: For patients with diabetes plus 1 major ASCVD risk		factor, treating to a non-HDL-C goal of <100 mg/dl (LDL-C of <70 mg/dL) is considered a therapeutic option.	

Requesting Provider

Name: Dr. Sarah Miller

HIV 1/2 ANTIGEN/ANTIBODY, FOURTH GENERATION W/RFL

Observations	Result	Reference / UoM	Date/Status
HIV AG/AB, 4TH GEN [1]	NON-REACTIVE	NON-REACTIVE	07/07/2023 02:37 pm

Back to top 6 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023

Observations	Result	Reference/ UoM	Date/ Status
Vendor note:	HIV-1 antigen and HIV-1/HIV-2 antibodies were not detected. There is no laboratory evidence of HIV infection.		

PLEASE NOTE: This information has been disclosed to you from records whose confidentiality may be protected by state law. If your state requires such protection, then the state law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

For additional information please refer to http://resources.communityassistance.org/faq/FAQ106 (http://resources.communityassistance.org/faq/FAQ106) (This link is being provided for informational/ educational purposes only.)

The performance of this assay has not been clinically validated in patients less than 2 years old.

MAGNESIUM

Observations	Result	Reference/UoM	Date/Status
MAGNESIUM [1]	2.1	1.5-2.5 mg/dL	07/07/2023 02:37 pm

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference/UoM	Date/ Status
GLUCOSE [1]	80	65-99 mg/dL	07/07/2023 02:37 pm
Vendor note:			

Observations	Result	Reference/UoM	Date/ Status
		Fasting reference interval	
UREA NITROGEN (BUN) [1]	10	7-25 mg/dL	07/07/2023 02:37 pm
CREATININE [1]	0.94	0.70-1.30 mg/dL	07/07/2023 02:37 pm
EGFR [1]	98	> OR = 60 mL/min/1.73m2	07/07/2023 02:37 pm
Vendor note:		The eGFR is based on the CKD-EPI 2021 equation. To calculate the new eGFR from a previous Creatinine or Cystatin C result, go to https://www.kidney.org/professionals/ (https://www.kidney.org/professionals/) kdoqi/gfr%5Fcalculator	
BUN/ CREATININE RATIO [1]	NOT APPLICABLE	6-22 (calc)	07/07/2023 02:37 pm
SODIUM [1]	139	135-146 mmol/L	07/07/2023 02:37 pm
POTASSIUM [1]	4.5	3.5-5.3 mmol/L	07/07/2023 02:37 pm
CHLORIDE [1]	105	98-110 mmol/L	07/07/2023 02:37 pm
CARBON DIOXIDE [1]	28	20-32 mmol/L	07/07/2023 02:37 pm
CALCIUM [1]	9.5	8.6-10.3 mg/dL	07/07/2023 02:37 pm
PROTEIN, TOTAL [1]	7.0	6.1-8.1 g/dL	07/07/2023 02:37 pm
ALBUMIN [1]	4.1	3.6-5.1 g/dL	07/07/2023 02:37 pm
GLOBULIN [1]	2.9	1.9-3.7 g/dL (calc)	07/07/2023 02:37 pm
	1.4	1.0-2.5 (calc)	

Observations	Result	Reference/UoM	Date/ Status
ALBUMIN/ GLOBULIN RATIO [1]			07/07/2023 02:37 pm
BILIRUBIN, TOTAL [1]	0.3	0.2-1.2 mg/dL	07/07/2023 02:37 pm
ALKALINE PHOSPHATASE [1]	125	35-144 U/L	07/07/2023 02:37 pm

Observations	Result	Reference / UoM	Date/Status
AST [1]	● 213	10-35 U/L Above high normal	07/07/2023 02:37 pm
ALT [1]	● 112	9-46 U/L Above high normal	07/07/2023 02:37 pm

SED RATE BY MODIFIED WESTERGREN

Observations	Result	Reference / UoM	Date/Status
SED RATE BY MODIFIED WESTERGREN [1]	9	< OR = 20 mm/h	07/07/2023 02:37 pm

CBC (INCLUDES DIFF/PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	9.8	3.8-10.8 Thousand/uL	07/07/2023 02:37 pm
RED BLOOD CELL COUNT [1]	4.81	4.20-5.80 Million/uL	07/07/2023 02:37 pm
HEMOGLOBIN [1]	13.3	13.2-17.1 g/dL	07/07/2023 02:37 pm
HEMATOCRIT [1]	40.1	38.5-50.0 %	07/07/2023 02:37 pm
MCV [1]	83.4	80.0-100.0 fL	07/07/2023 02:37 pm
MCH [1]	27.7	27.0-33.0 pg	07/07/2023 02:37 pm
MCHC [1]	33.2	32.0-36.0 g/dL	07/07/2023 02:37 pm

Observations	Result	Reference / UoM	Date/Status
RDW [1]	13.5	11.0-15.0 %	07/07/2023 02:37 pm
PLATELET COUNT [1]	217	140-400 Thousand/uL	07/07/2023 02:37 pm
MPV [1]	10.7	7.5-12.5 fL	07/07/2023 02:37 pm
ABSOLUTE NEUTROPHILS [1]	5664	1500-7800 cells/uL	07/07/2023 02:37 pm
ABSOLUTE LYMPHOCYTES [1]	3391	850-3900 cells/uL	07/07/2023 02:37 pm
ABSOLUTE MONOCYTES [1]	568	200-950 cells/uL	07/07/2023 02:37 pm
ABSOLUTE EOSINOPHILS [1]	147	15-500 cells/uL	07/07/2023 02:37 pm
ABSOLUTE BASOPHILS [1]	29	0-200 cells/uL	07/07/2023 02:37 pm
NEUTROPHILS [1]	57.8	%	07/07/2023 02:37 pm
LYMPHOCYTES [1]	34.6	%	07/07/2023 02:37 pm
MONOCYTES [1]	5.8	%	07/07/2023 02:37 pm
EOSINOPHILS [1]	1.5	%	07/07/2023 02:37 pm
BASOPHILS [1]	0.3	%	07/07/2023 02:37 pm

HEPATITIS C AB W/REFL TO HCV RNA, QN, PCR (REFL)

Observations	Result	Reference / UoM	Date/Status
HEPATITIS C ANTIBODY (REFL)	NON-REACTIVE	NON-REACTIVE	07/07/2023 02:37 pm

Observations	Result	Reference/UoM	Date/ Status
Vendor note:	miller, arthur 05/21/1965 Order #ZW106580F HCV antibody was non-reactive. There is no laboratory evidence of HCV infection. In most cases, no further action is required. However,		

Observations	Result	Reference/UoM	Date/ Status
		if recent HCV exposure is suspected, a test for HCV RNA (test code 35645) is suggested. For additional information please refer to http://education.genesisdiagnostics.com/faq/FAQ22v1 (http://education.genesisdiagnostics.com/faq/FAQ22v1) (This link is being provided for informational/ educational purposes only.) Our records indicate that you have ordered a client custom reflex order code. Only the initial test was performed because we do not have a client custom reflex testing authorization request form on file for you. Please contact a client service representative if you would like additional testing done on this patient or contact your sales representative to obtain a client custom reflex testing authorization request form.	

HEPATITIS B CORE ANTIBODY (IGM)

Observations	Result	Reference/UoM	Date/Status
HEPATITIS B CORE ANTIBODY (IGM)'	NON-REACTIVE	NON-REACTIVE	07/07/2023 02:37 pm
Vendor note:		For additional information, please refer to http://education.genesisdiagnostics.com/faq/FAQ202	

Observations	Result	Reference/UoM	Date/Status
		(http://education.genesisdiagnostics.com/faq/FAQ202) (This link is being provided for informational/ educational purposes only.)	

HSV 1 IGG, TYPE SPECIFIC AB

Observations	Result	Reference/UoM	Date/Status
HSV 1 IGG, TYPE SPECIFIC AB [1]	<0.90	index	07/07/2023 02:37 pm

https://static.compassionatecareconnect.com/apps/ehr/index.html#/PF/charts/patients/219c8624-5996-41e4-99e3-aa5287440202/results/17c748-c1726

Observations	Result	Reference / UoM	Date/Status
Vendor note:	Index		

Index Interpretation

| <0.90 | Negative 0.90-1.09 | Equivocal

1.09 | Positive

This assay utilizes recombinant type-specific antigens to differentiate HSV-1 from HSV-2 infections. A positive result cannot distinguish between recent and past infection. If recent HSV infection is suspected but the results are negative or equivocal, the assay should be repeated in 4-6 weeks. The performance characteristics of the assay have not been established for pediatric populations, immunocompromised patients, or neonatal screening.

For additional information, please refer to http://education.CommunityAssistance.org/faq/FAQ118 (http://education.CommunityAssistance.org/faq/FAQ118) (This link is being provided for informational/ educational purposes only.)

HSV 2 IGG, TYPE SPECIFIC AB

Observations	Result	Reference / UoM	Date/Status
HSV 2 IGG, TYPE SPECIFIC AB [1]	● 4.35	index	07/07/2023 02:37 pm
Vendor note:	Above high normal		

Index Interpretation

| <0.90 | Negative 0.90-1.09 | Equivocal

1.09 | Positive

This assay utilizes recombinant type-specific antigens to differentiate HSV-1 from HSV-2 infections. A positive result cannot distinguish between recent and past infection. If recent HSV infection is suspected but the results are negative or equivocal, the assay should be repeated in 4-6 weeks. The performance characteristics of the assay have not been established for pediatric populations, immunocompromised patients. or neonatal screening.

For additional information, please refer to http://education.CommunityAssistance.org/faq/FAQ118 (http://education.CommunityAssistance.org/faq/FAQ118) (This link is being provided for informational/ educational purposes only.)

FOLATE, SERUM

Observations	Result	Reference / UoM	Date/Status
FOLATE, SERUM [1]	14.7	ng/mL	07/07/2023 02:37 pm

https://static.compassionatecareconnect.com/apps/ehr/index.html#/PF/charts/patients/a1b2c3d4-e5f6-7890-1234-567890abcdef/results/f0e1d2c3-b4a5-6789-0123-456789fedcba Back to top 10 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023 04/18/2024 13:23 16145550102 PAGE 10/16 miller, arthur, 05/21/1965 Order #AB12345XYZ

Observations	Result	Reference / UoM	Date/Status
Vendor note:	Reference Range Low: <3.4 Borderline: 3.4-5.4 Normal: >5.4		

TSH

Observations	Result	Reference / UoM	Date/Status
TSH [1]	● <0.01	0.40-4.50 mIU/L Below low normal	07/07/2023 02:37 pm

VITAMIN B12

Observations	Result	Reference / UoM	Date/Status
VITAMIN B12 [1]	516	200-1100 pg/mL	07/07/2023 02:37 pm

VITAMIN D,25-OH,TOTAL,IA

Observations	Result	Reference / UoM	Date/Status
VITAMIN D,25-OH,TOTAL,IA [1]	● 25	30-100 ng/mL Below low normal	07/07/2023 02:37 pm
Vendor note: Vitamin D Status		25-OH Vitamin D: Deficiency: <20 ng/mL Insufficiency: 20 - 29 ng/mL Optimal: > or = 30 ng/mL For 25-OH Vitamin D testing on patients on D2-supplementation and patients for whom quantitation of D2 and D3 fractions is required, the GENESIS DIAGNOSTICS(TM) 25-OH VIT D, (D2,D3), LC/MS/MS is recommended: order code 92888 (patients >2yrs). See Note 1 Note 1 For additional information, please refer to http://education.GenesisDiagnostics.com/faq/FAQ199 (http://education.GenesisDiagnostics.com/faq/FAQ199)	

Observations	Result	Reference / UoM	Date/Status
		(This link is being provided for informational/ educational purposes only.)	

PSA (FREE AND TOTAL)

Observations	Result	Reference / UoM	Date/Status
PSA, TOTAL [1]	1.8	< OR = 4.0 ng/mL	07/07/2023 02:37 pm
PSA, FREE [1]	0.9	ng/mL	07/07/2023 02:37 pm
PSA, % FREE [1]	50	>25% (calc)	07/07/2023 02:37 pm

https://connect.compassionatecare.org/patient/abcde123-f456-7890-1234-abcdef567890/results/09876543-21fe-dcba-9876-543210fedcba Back to top 11 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023

Observations	Result	Reference / UoM	Date/Status
Vendor note:			
PSA(ng/mL)	Free PSA(%)	Estimated(x) Probability of Cancer(as%)	
0-2.5	()	Approx. 1	
2.6-4.0(1)	0-27(2)	24(3)	
4.1-10(4)	0-10	56	
	11-15	28	
	16-20	20	
	21-25	16	
>10(+)	>or =26	8	
	N/A	>50	

References:(1)Catalona et al.:Urology 60: 469-474 (2002) (2)Catalona et al.:J.Urol 168: 922-925 (2002) Free PSA(%) Sensitivity(%) Specificity(%) < or = 25 85 19 < or = 30 93 9 (3)Catalona et al.:JAMA 277: 1452-1455 (1997) (4)Catalona et al.:JAMA 279: 1542-1547 (1998)

(x)These estimates vary with age, ethnicity, family history and DRE results. ()The diagnostic usefulness of % Free PSA has not been established in patients with total PSA below 2.6 ng/mL. (+)In men with PSA above 10 ng/mL, prostate cancer risk is determined by total PSA alone.

The Total PSA value from this assay system is standardized against the equimolar PSA standard. The test result will be approximately 20% higher when compared to the WHO-standardized Total PSA (Siemens assay). Comparison of serial PSA results should be interpreted with this fact in mind.

PSA was performed using the Beckman Coulter Immunoassay method. Values obtained from different assay methods cannot be used interchangeably. PSA levels, regardless of value, should not be interpreted as absolute evidence of the presence or absence of disease.

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
HEMOGLOBIN A1c[1]	● 5.8	<5.7 % of total Hgb Above high normal	07/07/2023 02:37 pm

Observations	Result	Reference/ UoM	Date/ Status
Vendor note: For someone without known diabetes, a hemoglobin Alc value between 5.7% and 6.4% is consistent with prediabetes and should be confirmed with a follow-up test. For someone with known diabetes, a value <7% indicates that their diabetes is well controlled. Alc targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations. This assay result is consistent with an increased risk of diabetes.			

Observations	Result	Reference/ UoM	Date/ Status
Currently, no consensus exists regarding use of hemoglobin Alc for diagnosis of diabetes for children.			

SYPHILIS ANTIBODY CASCADING REFLEX

Observations	Result	Reference/ UoM	Date/ Status
T. PALLIDUM AB[1]	NEGATIVE	NEGATIVE	07/07/2023 02:37 pm
Vendor note: No antibodies to T. pallidum (the agent causing syphilis) were detected in the specimen. This result, however, does not exclude very recent T. pallidum infection; testing of a second specimen, collected 2-4 weeks after this specimen, is recommended if the index of suspicion for recent infection is high.			

PDF Report1

Observations	Result	Reference/UoM	Date/Status
See Attachment			07/06/2023 12:57 pm

Performing Laboratory CAP - Central Branch 246 Maple Dr Metropolis, NY 10001

https://static.compassionatecareconnect.com/apps/ehr/index.html#/PF/charts/patients/a1b2c3d4-e5f6-7890-1234-567890abcdef/results/f0e9d8c7*b6a5*41c3*2d1e*0f9e8d7c6b5a Back to top 13 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023

04/18/2024 13:23 16145550102 PAGE 13/16 miller, arthur 05/21/1965 Order #WX269612M Lab Results for miller, arthur (Male, 05/21/1965) Compassionate Care Connect

Laboratory Name: Community Assistance Program (CAPRT)

Patient Information Patient ID: am98765 Mobile: (773) 555-9876 Address: 789 Oak Ave Chicago, IL 60601

Attachments attachment1

Comment: file

Collection: 07/06/2023 01:08 pm Order #: WX269612M Accession #: WX269612M

Requesting Provider Name: Dr. Sarah Miller PhD

TRICHOMONAS VAGINALIS RNA QUALITATIVE TMA, MALES

Observations	Result	Reference / UoM	Date/Status
TRICHOMONAS VAGINALIS RNA QUALITATIVE TMA, MALES 1	NOT DETECTED	NOT DETECTED	07/07/2023 08:31 pm

Vendor note: The analytical performance characteristics of this assay have been determined by Community Assistance Program. The modifications have not been cleared or approved by the FDA. This assay has been validated pursuant to the CLIA regulations and is used for clinical purposes.

```
For additional information, please refer to
http://education.communityassistanceprogram.com/ (http://educatio
faq/Trichomonastma
(This link is being provided for informational/
educational purposes only.)
```

PDF Report1

Observations	Result	Reference / UoM	Date/Status
See Attachment			07/06/2023 01:08 pm

Performing Laboratory CAP - Riverside Office 789 River Rd Metropolis, NY 10002

https://secure.compassionatecareconnect.org/reports/am98765/results/488df78e-09ed-4831-a1a5

Lab Results for Arthur Miller (Male, 05/21/1965)

Laboratory

Name: Community Assistance Program (CAP)

Collection: 07/06/2023 01:08 pm Order #: YZ987654L Accession #: YZ987654L

Patient information

Patient ID: am987654 Mobile: (773) 555-9876 Address: 789 Oak Ave Chicago, IL 60601

Requesting Provider

Name: Dr. Sarah Miller PhD

Attachments

attachment1

Comment:

file

CHLAMYDIA/N. GONORRHOEAE RNA, TMA, UROGENITAL

Observations	Result	Reference / UoM	Date/Status
CHLAMYDIA TRACHOMATIS RNA, TMA, UROGENITAL [1]	NOT DETECTED	NOT DETECTED	07/07/2023 10:56 pm
NEISSERIA GONORRHOEAE RNA, TMA, UROGENITAL [1]	NOT DETECTED	:----------	:----------
COMMENT [1]			07/07/2023 10:56 pm

Vendor note: The analytical performance characteristics of this assay, when used to test SurePath(TM) specimens have been determined by Community Assistance Program. The modifications have not been cleared or approved by the Regulatory Agency. This assay has been validated pursuant to the CLIA regulations and is used for clinical purposes.

For additional information, please refer to https://info.communityassistanceprogram.org/faq/FAQ154 (https://info.communityassistanceprogram.org/faq/FAQ154) (This link is being provided for information/ educational purposes only.)

PDF Report1

Observations	Result Reference / UoM	Date/Status
See Attachment		07/06/2023 01:08 pm

Performing Laboratory

[1] CAP - Riverside Office 789 River Rd Metropolis, NY 10002

https://reports.compassionatecareconnect.org/charts/patients/abcdef12-3456-7890-abcd-ef1234567890/results/fedcba98-7654-3210-dcba-fedcba987654 Back to top 15 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023 PAGE 15/16

04/18/2024 13:23 16145550102

Sterling Health Clinic DR. ELIAS VANCE ☐ ELEANOR VANCE, D.O. ☐ DR. ANYA SHARMA, M.D. 456 Oak Avenue - Columbus, OH 43215 P. (614) 555-0101 F: (614) 555-0199 789 Pine Street - Worthington, OH 43085 P: (614) 555-0202 F: (614) 555-0299 101 Maple Lane - Grove City, OH 43123 P: (614) 555-0303 F: (614) 555-0399

Name Arthur Miller Date 7/7/23

Address

R DOB 05/21/1965

Diagnostic mammogram with ultrasound Dx: Lump on right areola

☐ Label Refill - 0 - 1 - 2 - 3 - 4 - PRN M.D. 16 of 16: 10F: Office Treatment Records - OFFCREC Src: Sterling Health Clinic 07/06/2023 - 07/07/2023 04/18/2024 13:23

GENESIS DIAGNOSTICS

| Patient: Miller, Arthur | Report Date: 7/7/2023 | | Date of Birth: 05/21/1965 | Client Order ID: | | Medical Record #: | | | Sex: Male | |

COLOGUARD (Final result) | ID: | 220278-012040 | Order ID: | 31784850 | | Collected: | 6/28/2023 0001 | Authorized by: | Dr. Elias Vance | | Received: | 6/29/2023 1921 | Type: | Stool | | Resulting Lab: | CLIA 52D2072838 | Source: | Per Rectum |

Test Result

Value	Normal Value
Negative	Negative

NEGATIVE TEST RESULT. A negative Cologuard result indicates a low likelihood that a colorectal cancer (CRC) or advanced adenoma (adenomatous polyps with more advanced pre-malignant features) is present. The chance that a person with a negative Cologuard test has a colorectal cancer is less than 1 in 1500 (negative predictive value >99.9%) or has an advanced adenoma is less than 5.3% (negative predictive value 94.7%). These data are based on a prospective cross-sectional study of 10,000 individuals at average risk for colorectal cancer who were screened with both Cologuard and colonoscopy (Imperiale T. et al, N Engl J Med 2014;370(14):1286-1297). The normal value (reference range) for this assay is negative.

COLOGUARD RE-SCREENING RECOMMENDATION Periodic colorectal cancer screening is an important part of preventive healthcare for asymptomatic individuals at average risk for colorectal cancer. Following a negative Cologuard result, the American Cancer Society and U.S. Multi-Society Task Force screening guidelines recommend a Cologuard re-screening interval of 3 years. References: American Cancer Society Guideline for Colorectal Cancer Screening: https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html.; Rex DK, Boland CR, Dominitz J K, Colorectal Cancer Screening: Recommendations for Physicians and Patients from the U.S. Multi-Society Task Force on Colorectal Cancer Screening. Am J Gastroenterology 2017; 112:1016-1030.

TEST DESCRIPTION Composite algorithmic analysis of stool DNA-biomarkers with hemoglobin immunoassay. Quantitative values of individual biomarkers are not reportable and are not associated with individual biomarker result reference ranges. Cologuard is intended for colorectal cancer screening of adults of either sex, 45 years or older, who are at average-risk for colorectal cancer (CRC). Cologuard has been approved for use by the U.S. FDA. The performance of Cologuard was established in a cross sectional study of average-risk adults aged 50-84. Cologuard performance in patients ages 45 to 49 years was estimated by sub-group analysis of near-age groups. Colonoscopies performed for a positive result may find as the most clinically significant lesion; colorectal cancer [4.0%], advanced adenoma (including sessile serrated polyps greater than or equal to 1cm diameter) [20%] or non- advanced adenoma [31%]; or no colorectal neoplasia [45%]. These estimates are derived from a prospective cross-sectional screening study of 10,000 individuals at average risk for colorectal cancer who were screened with both Cologuard and colonoscopy. (Imperiale T. et al, N Engl J Med 2014;370(14):1286-1297). Cologuard may produce a false negative or false positive result (no colorectal cancer or precancerous polyp present at colonoscopy follow up). A negative Cologuard test result does not guarantee the absence of CRC or advanced adenoma (pre-cancer). The current Cologuard screening interval is every 3 years. (American Cancer Society and U.S. Multi-Society Task Force). Cologuard performance data in a 10,000 patient pivotal study using colonoscopy as the referenced method can be accessed at the following location: www.exactlabs.com/results. Additional description of the Cologuard test process, warnings and precautions can be found at www.cologuard.com.

Resulting Lab

CLIA 52D2072838 GENESIS DIAGNOSTICS (CLIA #:52D2072838), 800-111-2222 789 Oak Avenue, Suite B, Rivertown, CA 90210 Director: Dr. Sophia Evans, Ph.D., ABMG