

**NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE  
DIVISION OF DISABILITY DETERMINATIONS**

(TOLL FREE: 1-800-

Date:

SSA Num:

Mod/Unit/Pin:

Order Num:

This agency is responsible for obtaining additional medical information in connection with your application or continuation of Social Security/SSI disability benefits. It WILL BE NECESSARY FOR YOU TO BE EXAMINED BY THE SPECIALIST NAMED BELOW REGARDING A BEHAVIOR PROBLEM. WE WILL PAY FOR ALL EXAMINATIONS AND TESTS REQUIRED, INCLUDING MENTAL EXAMINATION AND INTELLIGENCE EVALUATION.

Specialist:

Address:

Specialist's Telephone Number:

PHONE

FAX

You must keep this appointment at the time and date indicated below. Bring this notice and all medications you are taking.

My appointment is on \_\_\_\_\_ at \_\_\_\_\_ A.M. or P.M.

(Month) (Date) (Year)

Please call us IMMEDIATELY if you have any problem making the appointment with the specialist or getting to the specialist's office.

If you will have UNUSUAL expenses in traveling to the specialist's office you must let us know now so that we can make necessary arrangements BEFORE the examination.

If you do not speak English, or do not speak English well, we will provide you with an interpreter at no cost to you. Or, you may wish to bring your own interpreter with you such as a friend or family member. If you want us to provide an interpreter, please tell us ahead of time.

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YOU ARE EXPECTED TO MAKE AND KEEP THIS APPOINTMENT. IF YOU FAIL TO KEEP THIS APPOINTMENT, AND YOU DO NOT ADVISE US OF THE REASON YOU ARE UNABLE TO APPEAR FOR THE EXAMINATION, THE DECISION WILL BE MADE BASED ON THE INFORMATION IN YOUR CASE; AND IT MAY BE FOUND THAT YOU ARE NOT (OR NO LONGER) DISABLED OR BLIND.

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CE-5B

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/CE-5B-CEMD/CLMT/CC

**NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE  
DIVISION OF DISABILITY DETERMINATIONS**

**ORDER & VOUCHER FOR CONSULTATIVE EXAMINATION**

(Call us at \_\_\_\_\_ if you cannot fill this order. Changes must be authorized in advance.)

Payee ID: \_\_\_\_\_ Claimant: \_\_\_\_\_  
 Specialist: \_\_\_\_\_  
 Order No./Date: \_\_\_\_\_ Address: \_\_\_\_\_  
 Mod/Unit/PIN: \_\_\_\_\_  
 Claimant Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: / /

PROCEDURE CODE PROCEDURE	DESCRIPTION	AMOUNT FOR EACH
90003	PSYCHIATRIC EXAM: SUBMIT DETAILED TYPED NARRATIVE REPORT PER FORM DSS-4128 AND A DESCRIPTION OF ABILITY TO DO WORK RELATED ACTIVITIES.	
9800	INTELLIGENCE EVALUATION: ADMINISTER A SINGLE INTELLIGENCE TEST. SUBMIT DETAILED TYPED NARRATIVE REPORT PER REFERENCED FORMS AND A DESCRIPTION OF ABILITY TO DO WORK RELATED ACTIVITIES.	

FORM CODES DDD-4130 / DDD-4363 TOTAL

DO NOT ADD OR DELETE PROCEDURES WITHOUT PRIOR AUTHORIZATION FROM OUR OFFICE.  
RETURN TO:

Payee Certification: I certify that the above bill is just, true and correct; that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

Payee's Signature in ink	Title	Date	Company
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**AGENCY USE ONLY**

CE Complete as ordered Exam date: \_\_\_/\_\_\_/\_\_\_  
 Report Rec'd: \_\_\_/\_\_\_/\_\_\_  
 CE Auth'd with following changes: Cert. Sign/Date: \_\_\_/\_\_\_/\_\_\_

CE-7

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER  
 / /08/1111/1/S111 /CE-7 /CC

**NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE  
DIVISION OF DISABILITY DETERMINATIONS**

Toll Free: 1-800

Fax: 1-800-

In Reference to Claimant

SSN:  
Name:  
Address:

Order #:

**AUTHORIZATION TO RELEASE CONSULTATIVE EXAMINATION REPORT**

If you want a copy of the examination or test report sent to your doctor, please fill in the doctor's name and address, your address and telephone number, sign, date, and mail this form in the return preaddressed envelope immediately.

I hereby authorize the release of a copy of the medical report and all related test results performed in conjunction with my consultative examination by:

Specialist:  
Address:

to be sent to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand this authorization is valid for either 90 days from the date signed or until acted upon, whichever occurs first, unless sooner revoked in writing by me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number \_\_\_\_\_

CE-9

/ /08/1111/1/S111/

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