

## Part D: Documentation to Establish Disability

### Medical Evidence

If you have not been determined to have a disability, the State Disability Review Team will have to review medical information about you that supports your disability claim.

You must provide:

- All available medical information from physicians, psychologists, hospitals, therapists, counselors, etc.
- Medical evidence (medical records including office notes, treatment records, lab results and medications) for a period up to 12 months prior to the date of application and cover the timeframe for which the disability determination is being sought.

### Doctors seen since your impairments began:

Physician's Name \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

**Hospitalization or treatment at a clinic for your impairments:**

Name of Hospital or Clinic \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Name of Hospital or Clinic \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Name of Hospital or Clinic \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Name of Hospital or Clinic \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_

Name of Hospital or Clinic \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip code \_\_\_\_\_