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[www.firstreviewinc.com](http://www.firstreviewinc.com)

**Authorization for Requesting Social Security Status**

**To: Social Security Administration**

**Name**

**Date of Birth**

**Social Security No.**

I authorize the Social Security Administration to release information or records about me to:

**First Review, Inc.  
651 Holiday Drive  
Foster Plaza 5, Suite 300  
Pittsburgh, PA 15220**

I want this information released to a representative of First Review, Inc. to establish my Social Security Disability status, date of entitlement to Medicare and the basis for Medicare entitlement (disability or age) for the purposes of my Workers' Compensation claim.

**Please release the following information:**

- Social Security entitlement status;
- Date of SS entitlement;
- Date of application if still pending, basis for entitlement (disability, age, ESRD);
- Medicare status, date of entitlement for Medicare A, B, and D, Supplemental Security Income entitlement, Medicaid entitlement.

If not a current Social Security recipient, include number of eligible quarters.

I am the individual to whom the information/record applies, parent or legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security, I could be punished by a fine or imprisonment or both.

Signature: \_\_\_\_\_

Claimant: \_\_\_\_\_

(print name)

**DO NOT FILL OUT BELOW THIS LINE**

Is claimant currently a **Medicare** and/or **Medicaid (SSI)** recipient? Yes \_\_\_ No \_\_\_

Is claimant receiving:	<b>Medicare Part A</b> _____	Date of Entitlement _____
	<b>Medicare Part B</b> _____	Date of Entitlement _____
	<b>Medicare Part D</b> _____	Date of Entitlement _____

----- **If claimant is receiving Medicare/Medicaid benefits, do not continue to the next question.** -----

Is claimant receiving **SS Retirement Benefits**? Yes \_\_\_ No \_\_\_

Effective Date \_\_\_\_\_:

Is claimant receiving **SSD** benefits but is not yet a Medicare beneficiary? Yes \_\_\_ No \_\_\_

Date of entitlement to **SSD**: \_\_\_\_\_

Has a claim or request for hearing for **SSD/SSI** benefits been filed? Yes \_\_\_ No \_\_\_

Date of Application: \_\_\_\_\_

Is claimant insured for **SSD**? Yes \_\_\_ No \_\_\_

Initial PIA \_\_\_\_\_ 80% ACE \_\_\_\_\_ Fam Max \_\_\_\_\_

**SSA Representative Signature** \_\_\_\_\_ Date \_\_\_\_\_