

MEDICAL CONSULTANT'S REVIEW OF MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

SSN	
NAME	
NH's NAME (If CDB Claim)	
MRFCA COMPLETED BY (Identify DDS or RO)	
DATE OF SSA-4734-F4-SUP BEING REVIEWED	
TYPE OF CLAIM	LEVEL OF CLAIM
<input type="checkbox"/> Initial <input type="checkbox"/> CDR	<input type="checkbox"/> Initial <input type="checkbox"/> Recon <input type="checkbox"/> DHU

This form is to be completed ONLY when an SSA-4734-F4-SUP has been prepared and the reviewing medical consultant agrees that a mental RFC assessment is needed.

Section I serves to record agreement/disagreement with the four areas of the NARRATIVE assessment of mental RFC (i.e., Section III of the SSA-4734-F4-SUP). If the reviewing medical consultant finds that the evidence is insufficient, this finding also is to be recorded in Section 1.

Section II serves for the reviewing medical consultant to explain, in a DETAILED NARRATIVE FORMAT, the evidentiary bases for recording a disagreement in Section I or for concluding that the RFC narrative is deficient and prevents either agreement or disagreement with it.

I. SUMMARY OF AGREEMENT/DISAGREEMENT

If there is agreement with all four mental areas and with the adequacy of documentation, indicate agreement with checkmarks, but DO NOT COMPLETE SECTION II.

Indicate agreement/disagreement with the medical consultant's narrative discussion of the four mental areas by checkmark. IMPORTANT - Indicate disagreement ONLY for substantive issues, i.e., the medical findings clearly support conclusions contrary to that/those in the narrative assessment.

If a decision of agreement/disagreement cannot be made for a mental area because the narrative statement of mental RFC is incomplete, inadequate, or missing, check the block indicating this following the mental area.

CHECK ONLY ONE BLOCK FOLLOWING EACH OF THE FOUR MENTAL AREAS (A, B, C, and D)

	<u>AGREE</u>	<u>DISAGREE</u>	<u>NARRATIVE IS INCOMPLETE OR INADEQUATE</u>
A. UNDERSTANDING AND MEMORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. SUSTAINED CONCENTRATION AND PERSISTENCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. SOCIAL INTERACTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. ADAPTATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADDITIONAL DOCUMENTATION NEEDED	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

II. NARRATIVE DISCUSSION

Complete Section II ONLY for SUBSTANTIVE disagreement with the Narrative Statement or for SUBSTANTIVE deficiency in the documentation.

Present a complete and detailed NARRATIVE discussion of the basis for disagreement for EACH mental area checked as a disagreement in Section I.

In the NARRATIVE DISCUSSION, include a citation of the specific evidence that supports mental capacity conclusions that differ SUBSTANTIVELY from those presented in the narrative statement. If essential evidence is missing or incomplete, identify the evidence that is needed.

Continued On Attached Page

The Privacy and Paperwork Reduction Acts

See revised Privacy Act and Paperwork Reduction Act Statements below.

The information requested on this form is authorized by Section 223 and Section 1633 of the Social Security Act. The information provided will be used in making a decision on this claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and other agencies.

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 12 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

MEDICAL CONSULTANT'S SIGNATURE

MC CODE

DATE

SSA-392-SUP
(Medical Consultant's Review of Residual Functional Capacity Assessment)

PRIVACY ACT NOTICE

Collection and Use of Personal Information

Sections 223 and 1633 of the Social Security Act, as amended, authorize us to collect the information requested on this form. The information you provide will be used to make a decision on your claim. Your response is voluntary. However, failure to provide the requested information may prevent an accurate and timely decision on any claim filed, or could result in the loss of benefits.

We rarely use the information provided on this form for any purpose other than for determining entitlement to Social Security benefits. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of 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.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:

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 12 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*