

Guidelines for Escalating Cases with the Social Security Administration

Table of contents

Introduction.....	2
Communication guidelines	2
Establish a relationship with the local SSA field office.....	2
Become a secure email partner	2
Include sufficient details when requesting records.....	2
Keep detailed notes to summarize resolution attempts.....	3
Case escalation guidelines for Social Security income benefits.....	4
Step 1: Contact the SSA field office	4
Requesting Social Security files.....	4
Response time.....	4
Consult with your benefit specialist program attorney.....	4
Step 2: Escalate to the SSA field office management team	5
Step 3: Escalate to an area work incentives coordinator	5
Case escalation guidelines for Original Medicare eligibility issues	6
Step 1: Contact the SSA field office	6
Step 2: Escalate to the SSA field office management team	6
Step 3: Contact the SSA public affairs specialist.....	6
Appendix.....	7

Introduction

Benefit specialists and State Health Insurance Assistance Program (SHIP) counselors are encouraged to use this process when seeking assistance with Social Security (SSA) field offices for case-specific issues. This document provides benefit specialists, program attorneys, and SHIP counselors a process for escalating concerns. Questions about this process should be directed to the benefit specialist's program attorney or to the [Wisconsin SHIP Director](#).

Note: contact information for individual field office and regional SSA staff is not available publicly. Private contact information is available in the [Supplement to Guidelines for Escalating Cases with SSA](#), available on the confidential [disability and elder benefit specialist program SharePoint sites](#). SHIP counselors who lack access to these SharePoint sites should email the [SHIP Director](#) for contact information.

Communication guidelines

Establish a relationship with the local SSA field office.

Agency staff are encouraged to develop a relationship with their [local field office manager](#). Each field office implements processes unique to their office based on the needs in their service area. The needs within the field office's service area directly impacts how staff at that field office prioritize case work. Contact the [assigned area work incentives coordinator](#) for help contacting the field office manager, if needed.

Become a secure email partner

Becoming a secure email partner with the SSA is required to use this process. Contact the [SSA area systems coordinator](#) to confirm your agency has implemented the secure email process. Be prepared to provide your agency's IT support contact information to SSA if secure email access needs to be established.

Include sufficient details when requesting records

Agency staff must be specific about the information they need and its purpose when requesting records from SSA. SSA staff must consider the best source of evidence to provide the requested information to meet the business need, without releasing information that was not requested and/or does not meet the specified business need.

For example, a benefit planning query (BPQY) was developed to provide work incentives benefit specialists (WIBS) with the information they need to provide an in-depth, personalized benefits analysis. The information on a BPQY report may be helpful to a benefit specialist for another purpose but may also include more information than is necessary for the business need. If the [Consent for Release of Information](#) (3288) does not indicate a business need for a BPQY, the request is likely to be denied.

Fax the completed and signed 3288 with a cover sheet to your local field office. Indicate on the cover sheet the specific information and/or files you are requesting (for example, a DDE (Disability Determination Explanation) from a medical determination or benefit letters during a specific period). This will help SSA staff get you exactly what you need.

Keep detailed notes to summarize resolution attempts

Benefit specialists and SHIP counselors are encouraged to use the [Problem Tracking Template](#) to document communication with Social Security field offices on each case. The template is in the Tools for Professionals section of the [Medicare Outreach and Assistance Resources web page](#). This information must be included in each communication with the field office:

Subject line: ADRC Follow-Up Request to Office Management
(if applicable, add “DIRE NEED” and/or deadlines)

Copy and paste the following into your email and enter all applicable information for each bullet.

- Client name and/or Social Security number (SSN):
- SSA field office location:
- Date of contact with the SSA field office:
- Detailed description of the issue, including attempts to resolve the issue and date(s) actions were taken:
- Representative spoken to (if known), or a description of what was tried and didn't work:
- Response from representative:
- Date of email or eFax to the SSA field office:
- Description of the field office's response to your email or eFax:
- Date of referral to the [area work incentives coordinator](#):

Case escalation guidelines for Social Security income benefits

Step 1: Contact the SSA field office

Ask questions of and address concerns with a representative at the [SSA field office](#) first. Ask the representative for their name or unit code. (Note that SSA staff are not required to share their names due to security concerns, but they should at least share their unit code.)

Examples of appropriate questions and concerns include but are not limited to:

- Asking for a date last insured.
- Responding to a SSA field office's request for information.
- Confirming the status of a submitted document such as an appeal form or application.
- Asking for more information about an overpayment.

Some requests for information may require payment of a fee. For example, a request for information to complete a student loan forgiveness request requires a fee.

Requesting Social Security files

Benefit specialists must fax requests for copies of notices (for example, overpayment notices) or Social Security disability determination files to the appropriate office. See the [Appendix](#) for examples of completed 3288 consents to release information, and instructions on what to include in the request for the disability determination file.

Note: The signature on [Consent for Release of Information](#) (SSA-3288) must be **dated within the past 90 days** for SSA to release medical records.

Response time

Allow two weeks for the issue to be resolved before escalating a question, unless:

- The case involves a dire need.
- The representative hangs up during the call or engages in other unacceptable behavior during the call.
- The representative refuses to identify themselves. (They should share at least their unit code.)

Consult with your benefit specialist program attorney

Prior to escalating the case, the benefit specialist must consult with their program attorney if the matter requires consultation according to program policies and processes.

Applies to:
EBS
DBS
SHIP

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Step 2: Escalate to the SSA field office management team

Send a secure email or eFax to the [SSA field office management team](#) if the issue is unresolved after an appropriate amount of time as described in Step 1.

Note: Do not use encryption when using the SSA secure email system. Always include the customer's SSN when using the SSA secure email system.

Step 3: Escalate to an area work incentives coordinator

Escalate the matter to the [area work incentives coordinator](#) assigned to the local office if the office management team does not respond within two weeks (or sooner in cases of urgent need) or the issue is not resolved after talking to the team.

Case escalation guidelines for Original Medicare eligibility issues

Step 1: Contact the SSA field office

Contact the [SSA field office](#) for problems with:

- Enrolling individuals into Medicare Parts A or B.
- Conditional enrollment for the purposes of obtaining the [Qualified Medicare Beneficiary \(QMB\)](#) benefit. (Contact the [income maintenance agency](#) for QMB financial eligibility issues.)

If the SSA field office does not answer your call or if their phone lines are down, then document the attempt.

Step 2: Escalate to the SSA field office management team

Send a secure email or eFax to the [SSA field office management team](#) indicating the intent to enroll into Medicare. *Copy and paste the information below into your email and enter the information for each bullet:*

- Customer's name:
- Social Security number (SSN):
- Phone number:
- Specifics regarding attempts made to reach the field office and the result of those attempts:

This email or eFax will document the attempt for purposes of asking for [equitable relief](#) at a future date if enrollment is not effectuated timely within the enrollment period.

Note: do not use encryption when using the SSA secure email system. Always include the customer's SSN when using the SSA secure email system.

Step 3: Contact the SSA public affairs specialist

Escalate the concern by sending another secure email or eFax to the relevant [SSA field office](#) with the same information and copy the [SSA public affairs specialist](#) if an email or eFax does not resolve the issue within two weeks (or sooner in cases of urgent need).

Appendix

This appendix provides examples of how to complete the [Consent for Release of Information](#) (SSA-3288) to receive records from SSA for different purposes.

This example demonstrates how to request a customer's medical records for a disability case.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).

TO: Social Security Administration

Sample Customer Name	MM/DD/YYYY	xxx-xx-xxxx
*Full Name	*Date of Birth (MM/DD/YYYY)	*Full Social Security Number

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

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
	** PHONE NUMBER OF PERSON OR ORGANIZATION:

Benefit specialist or SHIP counselor name	Sample street address
Sample agency name	Sample city, WI, xxxxx
	xxx-xxx-xxxx

I want this information released because:

We may charge a fee to release information for non-program purposes.

I am receiving help with my disability claim and related benefits. This consent to disclose is valid until a decision is made on my claim.

***Please release the following information selected from the list below:**

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

- ☒ Verification of Social Security Number
- ☒ Current monthly Social Security benefit amount
- ☒ Current monthly Supplemental Security Income payment amount
- ☐ Social Security benefit amounts from date _____ to date _____
- ☐ Supplemental Security Income payment amounts from date _____ to date _____
- ☐ Medicare entitlement from date _____ to date _____
- ☐ Medical records from date _____ to date _____
- ☒ Complete medical records
- ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)
Consultative exams, award/denial notices, DDE, benefit applications, appeals, questionnaires, doctor reports, and determinations

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by fine of up to \$5,000.

*Signature: _____	*Date: MM/DD/YYYY
**Address: customer's address	**Daytime Phone: xxx-xxx-xxxx
**Relationship (if not the subject of the record): Self	**Daytime Phone: same



This example is written specifically for requesting information that may be needed to complete a long-term functional screen so that a customer may enroll in a long-term care program. The local field office may be able to provide this information by phone after receiving the signed 3288.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).

TO: Social Security Administration

Sample Customer Name	MM/DD/YYYY	xxx-xx-xxxx
*Full Name	*Date of Birth (MM/DD/YYYY)	*Full Social Security Number

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

*NAME OF PERSON OR ORGANIZATION:

*ADDRESS OF PERSON OR ORGANIZATION:

** PHONE NUMBER OF PERSON OR ORGANIZATION:

Benefit specialist or SHIP counselor name	Sample street address
Sample agency name	Sample city, WI, xxxxx
	xxx-xxx-xxxx

*I want this information released because:

We may charge a fee to release information for non-program purposes.

I am being screened for functional eligibility to enroll in a long-term care program.

*Please release the following information selected from the list below:

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. ☒ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ Social Security benefit amounts from date _____ to date _____
5. ☐ Supplemental Security Income payment amounts from date _____ to date _____
6. ☐ Medicare entitlement from date _____ to date _____
7. ☐ Medical records from date _____ to date _____
8. ☒ Complete medical records
9. ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)
diagnosis code(s), disability EOD, diary date _____

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by fine of up to \$5,000.

*Signature:	*Date: MM/DD/YYYY
**Address: customer's address	**Daytime Phone: xxx-xxx-xxxx
**Relationship (if not the subject of the record): Self	**Daytime Phone: same



In this example, the benefit specialist is requesting information related to an overpayment. It is important to ask only for the information needed to advocate for the customer's situation. Not all of the information included in this example will be needed for every overpayment. In fact, some overpayment cases may need information not included in this example.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. (*Signifies a required field. **These are not mandatory fields for the consent form to be acceptable. Please complete these fields in case we need to contact you about the consent form).

TO: Social Security Administration

Sample Customer Name	MM/DD/YYYY	xxx-xx-xxxx
*Full Name	*Date of Birth (MM/DD/YYYY)	*Full Social Security Number

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

*NAME OF PERSON OR ORGANIZATION:

*ADDRESS OF PERSON OR ORGANIZATION:

** PHONE NUMBER OF PERSON OR ORGANIZATION:

Benefit specialist or SHIP counselor name	Sample street address
Sample agency name	Sample city, WI, xxxxx
	xxx-xxx-xxxx

*I want this information released because:

We may charge a fee to release information for non-program purposes.

I have requested help to contest my alleged overpayment (OP).

*Please release the following information selected from the list below:

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

- ☒ Verification of Social Security Number
- ☒ Current monthly Social Security benefit amount
- ☒ Current monthly Supplemental Security Income payment amount
- ☐ Social Security benefit amounts from date _____ to date _____
- ☐ Supplemental Security Income payment amounts from date _____ to date _____
- ☐ Medicare entitlement from date _____ to date _____
- ☐ Medical records from date _____ to date _____
- ☒ Complete medical records
- ☒ Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

Due process notice(S) with details of TWP and IRWEs, OP period, payments made and recalculated values, earnings record, cause for OP, disability EOD

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 1746) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtains access to records about another person under false pretenses is punishable by fine of up to \$5,000.

*Signature:	*Date: MM/DD/YYYY
**Address: customer's address	**Daytime Phone: xxx-xxx-xxxx
**Relationship (if not the subject of the record): Self	**Daytime Phone: same

