

**REQUEST FOR ASSISTANCE
DISEASE COMPENSATION CLAIM**

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Social Security Number	Date of Birth
_____	_____
Last Name	First Name
To assure proper recording and filing, print legibly. Use correct Social Security number.	

I would appreciate assistance in understanding the deficiencies noted in the documentation supporting my disease compensation claim. Please call to discuss my claim documentation in more detail.

Name of Person to Call: _____

Tel. No: _____ (Include area code) *Best Times/Days to Call: _____ (include time zone)
*Between 8:00 a.m. and 5:00 p.m. Central Time

Can we leave a message if you are not available when we call? _____

When we call you will need to have the following documents with you so that we can discuss your claim documentation:

1. *Original Disease Criteria*
2. *Copies of all medical documents submitted to the Claims Office*

If you do not have these documents, please write the Claims Office and request copies. Do not return this form until you have all of these documents.

Date Signed

Signature of Claimant or her Attorney

MDL-926 Claims Office
PO Box 56666
Houston, Texas 77256