

# Request for Reassessment of Disability Benefits

Your Name: [Your Name]

Your Address: [Your Address]

Your City, State, Zip Code: [Your City, State, Zip Code]

Your Phone Number: [Your Phone Number]

Your Email Address: [Your Email Address]

Date: [Date]

Recipient Name: [Recipient's Name]

Recipient Title: [Recipient's Title]

Agency Name: [Agency Name]

Agency Address: [Agency Address]

Agency City, State, Zip Code: [Agency City, State, Zip Code]

Dear [Recipient's Name],

I am writing to formally request a reassessment of my disability benefits. My case number is [Case Number]. My condition has changed since my last assessment on [Date of Last Assessment], and I believe that my current situation warrants a reevaluation.

In the past months, I have experienced [Briefly explain changes in your condition]. I have attached medical documentation and reports to substantiate my request.

I appreciate your time and consideration regarding my request. Please let me know if you need any further information or documentation.

Sincerely,

[Your Name]