**You can use this letter to ask a health care professional for evidence to challenge a decision made about your Personal Independence Payment (PIP) claim. You can use the same letter whether you are submitting a Mandatory Reconsideration or an Appeal. Where you see something written in red, it means you will need to add or change something so that the letter is accurate for you.**

To: (*add name of professional*)

Address: (*add address of professional*)

Date: (*add date*)

Dear Sir/Madam

**Request for medical evidence**

Name: (*add your name*)

Address: (*add your address)*

D.o.B: (*add your date of birth)*

I am challenging a decision about my entitlement to Personal Independence Payment and I am writing to ask if you would offer some evidence that may help my case. Evidence from medical professionals can be extremely useful in helping decision makers at the Department for Work and Pensions (DWP) make correct decisions.

I would be very grateful if you could answer the questions that you think are relevant to my condition from the list below (and return them to me in the envelope provided. Please be aware that I am not in a position to pay for any report or information) (*Insert or delete as applicable*).

The challenge is about a decision made in (*add date mm/yy*) so I would be grateful if you could provide information based on how my condition affected me at that time.

The questions focus on my mental health rather than my physical health. But if you have information regarding my physical health, please include this at the end of the form. Thank you very much, in advance for any help you can provide towards my claim.

Yours faithfully,

(Add your name).

Please state what conditions I have been diagnosed with, and what medications, treatments and therapies have been prescribed or recommended.

Can you look at the questions below and add some information for the ones you think are relevant for me.

**When answering the relevant questions please think about my ability to perform each activity safely, to an acceptable standard, repeatedly (as necessary) and within a reasonable time. Please indicate where I am unable to perform these activities without either physical help, or someone prompting me to carry out the activities.**

1. To what extent do my condition(s) affect my ability to prepare food?
2. To what extent do my condition(s) affect my ability to take appropriate nutrition?
3. To what extent do my condition(s) affect my ability to manage therapy or monitor my health condition?
4. To what extent do my condition(s) affect my ability to wash or bathe?
5. To what extent do my condition(s) affect my ability to manage my toilet needs or incontinence?
6. To what extent do my condition(s) affect my ability to dress or undress?
7. To what extent do my condition(s) affect my ability to communicate verbally?
8. To what extent do my condition(s) affect my ability to read and understand signs symbols and words?
9. To what extent do my condition(s) affect my ability to engage with other people (who I both know and do not know) face-to-face?
10. To what extent do my condition(s) affect my ability to make budgeting decisions?
11. To what extent do my condition(s) affect my ability to plan and follow journeys (both those that are familiar and unfamiliar to me)?
12. To what extent do my condition(s) affect my ability to physically move around?

Signature Date Hospital/Surgery Stamp