

EXHIBIT I

BARCODE
 {@SERIAL} {@DMASITE} ({CORGDMAFLG})

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| EXAMINATION AUTHORIZATION FOR SOCIAL SECURITY AND SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS | | DDS CITY, STATE Local: Toll Free: Fax: | |
| APPROVED DATE AND TIME | AUTHORIZED BY: | ADJ # | AUTH. DATE |
| Return this form and report within 10 days after examination | | REPORT FAILED APPOINTMENTS WITHIN 24 HOURS. CALL: | |
| EXAM WITH: | | TID: | VEND: |
| FOR: | | PT: | AUTH: |
| | | WAVEND: | CASE: |
| | | SSN: | DOB: |
| | | PHONE: | |
| Our medical consultant is particularly interested in your evaluation of the following claimant allegations: | | | |

You are hereby authorized to provide the following medical service payable in accordance with our agency fee schedule.

| DESCRIPTION | BILLED AMT | STATE USE ONLY |
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SECONDARY VENDOR SERVICES:

RETURN ONE COPY TO DISABILITY DETERMINATION SERVICES FOR PAYMENT.

VENDOR'S CERTIFICATE: I hereby certify under penalty of perjury that the items and totals listed herein are proper charges for services furnished to the State of Washington, and that all services rendered have been provided without discrimination on the grounds of race, creed, color, national origin, sex, or age.

| | | |
|------------------------------------|----------|---------------------------------|
| PROVIDER SIGNATURE | DATE | TITLE |
| FOR STATE OFFICE USE ONLY | | |
| ADJUDICATOR'S APPROVAL FOR PAYMENT | | ACCOUNTING APPROVAL FOR PAYMENT |
| ADDOPER | L9CEVCHR | |