Date: [Insert Date]

Social Security Administration
[Insert Local Office Address]
[City, State, Zip Code]
Phone: [Insert Phone Number]

RE: Social Security Disability Insurance (SSDI) Benefit Verification

Recipient Name: [Insert Full Name]

Social Security Number: [Insert SSN - XXX-XX-XXXX]

Claim Number: [Insert Claim Number]

To Whom It May Concern,

This letter is to formally verify that the individual named above is currently receiving Social Security Disability Insurance (SSDI) benefits from the Social Security Administration.

Our records indicate the following benefit information:

- **Benefit Type:** Social Security Disability (SSDI)
- **Monthly Gross Amount:** $[Insert Amount]
- **Effective Date of Benefits:** [Insert Date]
- **Next Payment Date:** [Insert Date]
- **Medicare Deductions:** [Insert Amount, if applicable]

The monthly benefit is typically paid on the [Insert 1st, 2nd, 3rd, or 4th] [Insert Day of Week] of each month.

If you require further verification or have additional questions regarding these benefits, please contact the Social Security Administration at 1-800-772-1213 or visit our website at www.ssa.gov.

Sincerely,

[Signature of Authorized Official]
[Name of Authorized Official]
[Title/Position]
Social Security Administration