



Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

DECISION REVIEW REQUEST: HIGHER-LEVEL REVIEW

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 5. Use this form to request a Higher-Level Review of a decision you received. A Higher-Level Review is a new review of an issue(s) previously decided by VA based on the evidence of record at the time of the prior decision. For more information call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms.

SECTION I - VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

Jãñe

☐ Doé

2. SOCIAL SECURITY NUMBER

1

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9

3. VA FILE NUMBER (If applicable)

9

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2

4. DATE OF BIRTH (MM/DD/YYYY)

1

2

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3

1

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1

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6

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5. VA INSURANCE POLICY NUMBER (If applicable)

9

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1

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6. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)

No. & Street

123 Somestreet

Apt./Unit NumberCity

Sometown

State/ProvinceCountry

U S

ZIP Code/Postal Code

66002

-

☐ I AM HOMELESS OR AT RISK OF HOMELESSNESS

7. TELEPHONE NUMBER (Include Area Code)

5

5

5

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8

0

0

-

1

1

1

1

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS (Optional)

josie@example.com

SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION (If other than veteran)

9. CLAIMANT'S NAME (First, Middle Initial, Last)

Betty

☐ Boop

10. SOCIAL SECURITY NUMBER (If applicable)

-

-

11. DATE OF BIRTH (MM/DD/YYYY) (If applicable)

-

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12. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)

No. & Street

456 First St

Apt./Unit NumberCity

Detroit

State/ProvinceCountry

U S

ZIP Code/Postal Code

66002

-

13. TELEPHONE NUMBER (Include Area Code)

-

-

Enter International Phone Number (If applicable)

14. E-MAIL ADDRESS (Optional)

claimant@email.com

SECTION III - BENEFIT TYPE

15. SELECT ONLY ONE (If you file for multiple benefit types, you must complete a separate VA Form 20-0996 for each benefit type.)

☐ COMPENSATION

☐ PENSION/SURVIVORS BENEFITS

☒ FIDUCIARY

☐ EDUCATION

☐ VETERANS HEALTH ADMINISTRATION

☐ VETERAN READINESS AND EMPLOYMENT

☐ LOAN GUARANTY

☐ LIFE INSURANCE

☐ NATIONAL CEMETERY ADMINISTRATION

VA FORM 20-0996
APR 2021

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16. YOU OR YOUR AUTHORIZED REPRESENTATIVE MAY REQUEST AN INFORMAL CONFERENCE WITH THE HIGHER-LEVEL REVIEWER FOR THE SOLE PURPOSE OF POINTING OUT ERRORS OF FACT OR LAW IN THE PRIOR DECISION. (VA will only conduct one informal conference by telephonic communication associated with this request for Higher-Level Review.)

16B. IF YOU SELECTED THE BOX ABOVE, VA will make two attempts to contact you OR your representative to schedule the informal conference. Contact attempts will be between the hours of 8:00 a.m. and 4:30 p.m. Eastern Time. INDICATE ONE PREFERENCE:

☐ Call me between 12:00 p.m. - 4:30 p.m. ET

☐ Call my representative between 12:00 p.m. - 4:30 p.m. ET

17. IF YOU WOULD LIKE VA TO CONTACT YOUR REPRESENTATIVE, YOU MUST PROVIDE YOUR REPRESENTATIVE'S CONTACT INFORMATION BELOW.

17A. REPRESENTATIVE'S NAME (First, Last)

Holly

17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code)

+6-555-800-1111

17C. REPRESENTATIVE'S E-MAIL ADDRESS

18. By marking the circle below, I ELECT TO PARTICIPATE IN THE MODERNIZED REVIEW SYSTEM for the following issues decided in a Statement of the Case (SOC) or Supplemental Statement of the Case (SSOC). I am withdrawing the eligible appeal issues listed in 19A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn. TO OPT-IN, THE CIRCLE BELOW **MUST** BE MARKED.

OPT-IN FROM SOC/SSOC

NOTE: Add the date of the SOC or SSOC in block 19B for all appeal issues being withdrawn.

19. INDICATE EACH ISSUE DECIDED BY VA FOR WHICH YOU ARE REQUESTING A HIGHER-LEVEL REVIEW. Refer to your decision notice(s) for a list of adjudicated issues. For each issue, identify the date of VA's most recent decision on the issue. You may attach additional sheets, if necessary - include your name and file number on each additional sheet. **IMPORTANT: You may only** list issues for the benefit type selected in Section III. A separate form is required for each benefit type.

19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)

19B. DATE OF VA DECISION NOTIFICATION
LETTER (REQUIRED)

Example 1: Service connection for left knee
Example 2: Earlier effective date for hearing loss
Example 3: Reimbursement for non-VA emergency care
Example 4: Denial of entitlement to VR&E benefits and services
Example 5: Entitlement to Service-Disabled Veterans Insurance

MM/DD/YYYY
MM/DD/YYYY
MM/DD/YYYY
MM/DD/YYYY
MM/DD/YYYY

tinnitus

SOC/SSOC Date: 08-01-2020

0	1	−	0	1	−	1	9	0	0
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left knee

0	1	−	0	2	−	1	9	0	0
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right knee

0	1	−	0	3	−	1	9	0	0
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PTSD

0	1	–	0	4	–	1	9	0	0
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Traumatic Brain Injury

$$\begin{array}{|c|c|} \hline 0 & 1 \\ \hline \end{array} - \begin{array}{|c|c|} \hline 0 & 5 \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline 1 & 9 & 0 & 0 \\ \hline \end{array}$$

right shoulder

0	1	−	0	6	−	1	9	0	0
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