OMB Control No. 2900-0862 Respondent Burden: 15 minutes Expiration Date: 4/30/2024

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Department of Veterans Affairs

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

VA DATE STAMP DO NOT WRITE IN THIS SPACE

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)									
Jane Z Doe									
2. SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. DATE OF BIRTH (MM/DD/YYYY)									
1 2 3 - 4 5 - 6 7 8 9 9 8 7 6 5 4 3 2 1 2 - 3 1 - 1 9 6 9	9								
5. VA INSURANCE POLICY NUMBER (If applicable)									
9 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 9									
6. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)									
No. & Street 123 Main St Suite #1200 Box 4									
Apt./Unit Number City New York									
State/Province NY Country US ZIP Code/Postal Code 3 0 0 1 2 -									
I AM HOMELESS OR AT RISK OF HOMELESSNESS									
7. TELEPHONE NUMBER (Include Area Code)									
Enter International Phone Number (If applicable) +34-555-800-1111 ex2									
8. E-MAIL ADDRESS (Optional)									
See attached page for veteran email									
SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION (If other than veteran)									
9. CLAIMANT'S NAME (First, Middle Initial, Last)									
10. SOCIAL SECURITY NUMBER (If applicable) 11. DATE OF BIRTH (MM/DD/YYYY) (If applicable)									
12. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)									
No. &									
Street									
Apt./Unit Number City									
State/Province Country ZIP Code/Postal Code — —									
13. TELEPHONE NUMBER (Include Area Code)									
Enter International Phone Number (If applicable)									
14. E-MAIL ADDRESS (Optional)									
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									
© COMPENSATION PENSION/SURVIVORS BENEFITS FIDUCIARY EDUCATION VETERANS HEALTH ADMINISTRATION VETERAN READINESS AND EMPLOYMENT LOAN GUARANTY LIFE INSURANCE NATIONAL CEMETERY ADMINISTRATION	N								

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VA FORM

SECTION IV - OPTIONAL INFORMAL CONFERENCE							
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.)							
16A. I WOULD LIKE AN INFORMAL CONFERENCE. I understand electing an informal conference is optional and	d may delay a decision.						
16B. IF YOU SELECTED THE BOX ABOVE, VA will make two attempts to contact you OR your representative to will be between the hours of 8:00 a.m. and 4:30 p.m. Eastern Time. INDICATE ONE PREFERENCE:	schedule the informal conference. Contact attempts						
Call me between 8:00 a.m 12:00 p.m. ET Call me between 12:00) p.m 4:30 p.m. ET						
	between 12:00 p.m 4:30 p.m. ET						
17. IF YOU WOULD LIKE VA TO CONTACT YOUR REPRESENTATIVE, YOU MUST PROVIDE YOUR REPRESENTA 17A. REPRESENTATIVE'S NAME (First, Last)	TIVE'S CONTACT INFORMATION BELOW.						
Helen Holly							
17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code)							
5 5 5 - 8 0 0 - 1 1 1 1 x2 17C. REPRESENTATIVE'S E-MAIL ADDRESS							
See attached page for representative email							
SECTION V - SOC/SSOC OPT-IN FROM LEGACY APPEAL							
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.							
SECTION VI - ISSUES FOR HIGHER-LEVEL REVIE							
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)							
tample 1: Service connection for left knee Amm/DD/YYYY Ammple 2: Earlier effective date for hearing loss Amm/DD/YYYY Ammple 3: Reimbursement for non-VA emergency care Amm/DD/YYYY Ammple 4: Denial of entitlement to VR&E benefits and services Amm/DD/YYYY Ammple 5: Entitlement to Service-Disabled Veterans Insurance Amm/DD/YYYY Ammple 5: MM/DD/YYYY							
	SOC/SSOC Date: 04-30-2020						
tinnitus	0 1 - 0 1 - 1 9 0 0						
left eye	0 1 - 0 2 - 1 9 0 0						
Tere eye							
right eye	0 1 - 0 3 - 1 9 0 0						
SOC/SSOC Date: 05-15-2019							
left ear	0 1 - 0 4 - 1 9 0 0						
Terc ear							
right ear	0 1 - 0 5 - 1 9 0 0						
	0 1 - 0 6 - 1 9 0 0						
migraines	01-06-1900						
left knee	0 1 - 0 7 - 1 9 0 0						

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SECTION VI - ISSUES FOR HIGHER-LEVEL REVIEW (Co	nti	nu	ed)								
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)										
	L			1			1				_
right knee		0	1	<u> </u>	0	8	_	1	9	0	0
	L			ı			1				
left foot	L	0	1	_	0	9	_	1	9	0	0
	,	S0(c / s	SSOC	ת י־	ate	-:	01.	-08	-20	21
	۱,	_		1			1				
right foot		0	1	_	1	0	<u> </u>	1	9	0	0
	l	_		7	4		7	4		•	
left hand		0	1		1	1		1	9	0	0
	l	_	4	1	4		7	4	0	0	•
right hand		0	1		1	2		1	9	0	0
form		0	1	1	1	3	1	1	9	0	0
fever	<u> </u>	<u> </u>	<u> </u>			<u> </u>	_		9	U	
SECTION VII - CERTIFICATION AND SIGNATUR		b.	١/٨	Farm	21.0	072	Λ /4	0 500	to Cie		
NOTE: This section is MANDATORY and completion is required to process your claim unless accompar <i>Certification</i> or Section VIII is completed.	ilea	Бу	VA	Form	21-0	J972,	, Alti	erna	ie Sig	ner	
I CERTIFY the statements on this form are true and correct to the best of my knowledge and belief.											
() /	20B	. D	ATE	SIGN	ED						
Jane Z Doe - Signed by digital authentication to api.va.gov		0	2	_	0	3	_	2	0	2	1
SECTION VIII - AUTHORIZED REPRESENTATIVE SIGN	ΑT	UR	E								
I CERTIFY the statements on this form are true and correct to the best of my knowledge and belief.											
NOTE: A representative's signature will not be accepted unless at the time of submission of this request a										Veter	rans
Service Organization as Claimant's Representative, or VA Form 21-22a, Appointment of Individual as Cla appropriate representative is of record with VA or included with this application.	IIME	ants	s Re	orese	entati	ve, ii	паіс	aung	ıne		
21A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)											
						П					
21B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink)	21C	. D	ATE S	SIGNE	ΕD						
				_			_				
PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful s	subr	mis	sion	of an	y sta	item	ent o	or ev	idenc	e of a	а
material fact, knowing it to be false.											
PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than	wha	at h	as b	een a	autho	orize	d un	der t	he Pr	ivacv	/

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain.

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Veteran Email:

Representative Email:

Additional Issues

A. Specific Issue(s)	B. Date of Decision	C. SOC/SSOC Date
lupus	1900-01-14	09-23-2020
cooties	1900-01-15	