OMB Control No. 2900-0862
Respondent Burden: 15 minutes
Expiration Date: 2/28/2022

Department of Veterans Affairs

# DECISION REVIEW REQUEST: HIGHER-LEVEL REVIEW

**VA DATE STAMP**
**DO NOT WRITE IN THIS SPACE**

**INSTRUCTIONS:** PLEASE READ THE PRIVACY ACT NOTICE AND RESPONDENT BURDEN INFORMATION ON PAGE 1 BEFORE COMPLETING THIS FORM.

## PART I - CLAIMANT'S IDENTIFYING INFORMATION

**NOTE:** You can either complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing the form.

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

Jane Z Doe

2. VETERAN'S SOCIAL SECURITY NUMBER

123-45-6789

3. VA FILE NUMBER *(If applicable)*

987654321

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*

Month 12 Day 31 Year 1969

5. VETERAN'S SERVICE NUMBER *(If applicable)*

87654321

6. INSURANCE POLICY NUMBER *(If applicable)*

9876543211234567 89

7. CLAIMANT'S NAME *(First, Middle Initial, Last) (If **other** than veteran)*

8. CLAIMANT TYPE:

☐ VETERAN ☐ VETERAN'S SPOUSE ☐ VETERAN'S CHILD ☐ VETERAN'S PARENT ☐ OTHER *(Specify)*

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

No. & Street: USE ADDRESS ON FILE

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code

10. TELEPHONE NUMBER *(Include Area Code)*

+34-555-800-1111 ex2

11. E-MAIL ADDRESS *(Optional)*

josie@example.com

12. BENEFIT TYPE: **PLEASE CHECK ONLY ONE** *(If you would like to file for multiple benefit types, you must complete a separate request form for each benefit type.)*

☐ COMPENSATION ☐ PENSION/SURVIVORS BENEFITS ☐ FIDUCIARY ☐ EDUCATION ☐ VETERANS HEALTH ADMINISTRATION
☐ VOCATIONAL REHABILITATION AND EMPLOYMENT ☐ LOAN GUARANTY ☐ INSURANCE ☒ NATIONAL CEMETERY ADMINISTRATION

## PART II - HIGHER-LEVEL REVIEW OPTIONS

13. IF YOU WOULD LIKE THE SAME OFFICE THAT ISSUED YOUR PRIOR DECISION TO CONDUCT THE REVIEW, YOU CAN MAKE THAT REQUEST BY CHECKING THE BOX BELOW. IF YOU DO NOT CHECK THE BOX, VA WILL TAKE THAT AS A REQUEST TO HAVE A DIFFERENT OFFICE CONDUCT THE REVIEW. *(Please note VA may be unable to grant your request.)*

☒ If available, I would like **HIGHER-LEVEL REVIEW** conducted at the same office within the agency of original jurisdiction.

14. IN ADDITION, YOU OR YOUR AUTHORIZED REPRESENTATIVE MAY REQUEST AN INFORMAL CONFERENCE WITH THE HIGHER-LEVEL REVIEWER. (*This is a telephonic communication 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 associated with this request for higher-level review. Check the box below to request an informal conference.)*

☒ I, or my representative, would like an **informal conference**. *(VA will make up to two attempts to call you between 8:00a.m. and 4:30p.m. Eastern Standard Time at the telephone number and time period you select below to **schedule your informal conference**. Please select up to two time periods you are available to receive a phone call.)*

☐ 8:00a.m. - 10:00a.m. ☐ 10:00a.m. - 12:30p.m. ☒ 12:30p.m. - 2:00p.m. ☒ 2:00p.m. - 4:30p.m.

If you would like for VA to contact your representative, please provide your representative's name and telephone number where he or she can be reached at the above checked time.

Helen Holly +6-555-800-1111 ext2

## PART III - ISSUES FOR HIGHER-LEVEL REVIEW

15. YOU MUST INDICATE BELOW EACH ISSUE DECIDED BY VA FOR WHICH YOU ARE REQUESTING A HIGHER-LEVEL REVIEW. *Please refer to your decision notice(s) for a list of adjudicated issues. for each issue, please identify the date of VA's decision. You may attach additional sheets, if necessary. Please include your name and file number on each additional sheet.*

*Check this box if any issue listed below is being withdrawn from the legacy appeals process.* ☐ **OPT-IN from SOC/SSOC**

| 15A. SPECIFIC ISSUE(S) | 15B. DATE OF VA DECISION NOTICE |
|---|---|
| tinnitus | 1900-01-01 |
| left knee | 1900-01-02 |
| right knee | 1900-01-03 |
| PTSD | 1900-01-04 |
| Traumatic Brain Injury | 1900-01-05 |
| right shoulder | 1900-01-06 |

## PART IV - CERTIFICATION AND SIGNATURE

**NOTE:** This section is **MANDATORY** and completion is required to process your claim; any omission may delay claim processing time.

**VA AUTHORIZED REPRESENTATIVES ONLY:** I certify that the claimant has authorized the undersigned representative to file this higher-level review on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

**NOTE**: A power of attorney's (POA's) signature ***will not*** be accepted unless at the time of submission of this request a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual As Claimant's Representative,* indicating the appropriate POA is of record with VA.

**I CERTIFY THAT** the statements on this form are true and correct to the best of my knowledge and belief.

| 16A. SIGNATURE OF VETERAN OR CLAIMANT OR VA AUTHORIZED REPRESENTATIVE *(Sign in ink)* | 16B. DATE SIGNED |
|---|---|
| Jane Z Doe | 01/01/2020 |

16C. NAME OF VA AUTHORIZED REPRESENTATIVE *(Please Print)*

## ALTERNATE SIGNER CERTIFICATION AND SIGNATURE

17. **I CERTIFY THAT** by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

| 17A. SIGNATURE OF ALTERNATE SIGNER *(Sign in ink)* | 17B. DATE SIGNED |
|---|---|
| | |

17C. NAME OF ALTERNATE SIGNER *(Please Print)*

**PENALTY:** The law provides severe penalties which include a fine, imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.