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

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 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/yaforms.

VA DATE STAMP DO NOT WRITE IN THIS SPACE

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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 Doe	
2. SOCIAL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. DATE OF BIRTH (MM/DD/YYYY)	
	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 USE ADDRESS ON FILE	
Apt./Unit Number City	
State/Province Country ZIP Code/Postal Code 6 6 0 0 2 -	
O I AM HOMELESS OR AT RISK OF HOMELESSNESS	
7. TELEPHONE NUMBER (Include Area Code)	
_ Enter International Phone Number (If applicable) USE PHONE ON FILE	
8. E-MAIL ADDRESS (Optional)	
USE EMAIL ON FILE	
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	

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SECTION IV - OPTIONAL INFORMAL CONFEREN	CE									
16. YOU OR YOUR AUTHORIZED REPRESENTATIVE MAY REQUEST AN INFORMAL CONFERENCE WITH THE HI PURPOSE OF POINTING OUT ERRORS OF FACT OR LAW IN THE PRIOR DECISION. (VA will only conduct one associated with this request for Higher-Level Review.)										n
16A. I WOULD LIKE AN INFORMAL CONFERENCE. I understand electing an informal conference is optional art	nd may	delay	a de	cision	١.					
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:	sched	ule the	e info	rmal o	confe	rence	. Co	ntact	atten	npts
Call me between 8:00 a.m 12:00 p.m. ET) p.m	4:30	p.m.	ET						
Call my representative between 8:00 a.m 12:00 p.m. ET Call my representative								1.014	,	
 IF YOU WOULD LIKE VA TO CONTACT YOUR REPRESENTATIVE, YOU MUST PROVIDE YOUR REPRESENTATIVE. REPRESENTATIVE'S NAME (First, Last) 	TIVES	CON	HAC	IINF	ORIVI	AHO	NBE	LOVV		
17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code)										
17C. REPRESENTATIVE'S E-MAIL ADDRESS										
										1
SECTION V - SOC/SSOC OPT-IN FROM LEGACY APPEAL	S SY	STE	М							
18. By marking the circle below, I ELECT TO PARTICIPATE IN THE MODERNIZED REVIEW SYSTEM for the following Supplemental Statement of the Case (SSOC). I am withdrawing the eligible appeal issues listed in 19A in their entine legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn. TO O	ety, and	d any	asso	ciated	l hear	ing re	eques	sts, fr	om th	é
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	-W									
19. INDICATE EACH ISSUE DECIDED BY VA FOR WHICH YOU ARE REQUESTING A HIGHER-LEVEL REVIEW. R		your c	decisi	on no	tice(s) for a	a list	of ad	iudica	ited
issues. For each issue, identify the date of VA's most recent decision on the issue. You may attach additional shee each additional sheet. IMPORTANT: You may only list issues for the benefit type selected in Section III. A separa	ts, if ne	cessa	ary - i	nclude	e you	r nam	ne an	d file		
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)								ON	
Example 1: Service connection for left knee Example 2: Earlier effective date for hearing loss		DD/Y\								
Example 3: Reimbursement for non-VA emergency care	MM/[DD/Y\ DD/Y\	ΥΥΥ							
Example 4: Denial of entitlement to VR&E benefits and services Example 5: Entitlement to Service-Disabled Veterans Insurance		DD/Y\ DD/Y\								
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SECTION VI - ISSUES FOR HIGHER-LEVEL REVIEW (Continued)												
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)										ON	
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SECTION VII - CERTIFICATION AND SIGNATUR	E											
NOTE: This section is MANDATORY and completion is required to process your claim unless accompar <i>Certification</i> or Section VIII is completed.	nied	by '	VA F	orm	21-0	972	, Alt	erna	te Si	gner		
I CERTIFY the statements on this form are true and correct to the best of my knowledge and belief.												
20A. SIGNATURE OF VETERAN OR CLAIMANT (Sign in ink) Jane Z Doe	20B.	. DA	ATE S	SIGN	ED		_					
- Signed by digital authentication to api.va.gov		0	1	<u> </u>	0	1	<u> </u>	2	0	2	0	
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 Service Organization as Claimant's Representative, or VA Form 21-22a, Appointment of Individual as Cla										Vete	rans	
appropriate representative is of record with VA or included with this application.												
21A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)	_	_										
21B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink)	21C.	DA	TE S	SIGNI	ΞD		7					
				_			_					
PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful smaterial fact, knowing it to be false.	subr	niss	ion	of ar	ıy sta	item	ent	or ev	iden	ce of	а	
PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than											y	
Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enfor epidemiological or research studies, the collection of money owed to the United States, litigation in which										ıs,		
interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilita	and	d pe	rsor	nel	admii	nistr	atio	า) as	iden	tified	in	

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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