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/vaforms.

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)									
Jäñe Ø Doé									
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									
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									
Apt./Unit Number City wwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwww									
State/Province Country U S ZIP Code/Postal Code WWWWWWWWWWWWWWW -									
○ I AM HOMELESS OR AT RISK OF HOMELESSNESS									
7. TELEPHONE NUMBER (Include Area Code)									
Enter International Phone Number (If applicable) +WWW-WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW									
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)									
Betty Boop									
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 wwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwww									
State/Province Country US ZIP Code/Postal Code WWWWWWWWWWWWWWWW -									
13. TELEPHONE NUMBER (Include Area Code)									
Enter International Phone Number (If applicable)									
14. E-MAIL ADDRESS (Optional)									
See attached page for claimant email									
CECTION III DENECT TYPE									
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.)									
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 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 art	16A. I WOULD LIKE AN INFORMAL CONFERENCE. I understand electing an informal conference is optional and 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	3					
Call me between 8:00 a.m 12:00 p.m. ET) 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 REPRESENTATIVE. TALL REPRESENTATIVE'S NAME (First, Last)	TIVE'S CONTACT INFORMATION BELOW.						
	WWWWWWWWWWWWWWW						
17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code)							
+www-wwwwwwwwww	WWWWWWWWWWWWW						
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 Supplemental Statement of the Case (SSOC). I am withdrawing the eligible appeal issues listed in 19A in their entire legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn. TO O	ety, and any associated hearing requests, from the	r					
OPT-IN FROM SOC/SSOC	F1-IN, THE CIRCLE BELOW MUST BE WARRED.						
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. Resissues. 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 necessary - include your name and file number						
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)	ſ					
Example 1: Service connection for left knee Example 2: Earlier effective date for hearing loss	MM/DD/YYYY MM/DD/YYYY						
Example 3: Reimbursement for non-VA emergency care Example 4: Denial of entitlement to VR&E benefits and services	MM/DD/YYYY MM/DD/YYYY						
Example 5: Entitlement to Service-Disabled Veterans Insurance tinnitus	MM/DD/YYYY						
CIIIIICus	SOC/SSOC Date: 08-01-2020)					
Area of Disagreement:	W 0 1 - 0 1 - 1 9 0 0						
left knee							
Area of Disagreement:	w 0 1 - 0 2 - 1 9 0 0	П					
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Area of Disagreement:	0 1 - 0 3 - 1 9 0 0						
PTSD							
Area of Disagreement: wwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwww	W 0 1 - 0 4 - 1 9 0 0						
Traumatic Brain Injury							
Area of Disagreement:		_					
<u>мимимимимимимимимимимимимимимимимимими</u>	W 0 1 — 0 5 — 1 9 0 0						
right shoulder							
Area of Disagreement:	0 1 - 0 6 - 1 9 0 0						
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SECTION VI - ISSUES FOR HIGHER-LEVEL REVIEW (Continued)										
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19E	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)								
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SECTION VII - CERTIFICATION AND SIGNATURI	E									
NOTE: This section is MANDATORY and completion is required to process your claim unless accompanies or Section VIII is completed.	nied by \	VA F	orm	21-0	972,	Alte	rnate	Sign	ner	
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) Betty Boop	20B. DA	ATE S	IGNE	ED						
- Signed by digital authentication to api.va.gov	0	2	_	0	3	<u>-</u> [2	0	2	1
SECTION VIII - AUTHORIZED REPRESENTATIVE SIGNATURE										
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	a valid V	/A Fo	orm 2	21-22 ntati	2, App	niod dica	tmen	t of V	etera	ans
appropriate representative is of record with VA or included with this application.	annant 3	πορ	7030	man	vC, III	uica	ung t	110		
21A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)										
21B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink)	21C. DA	TE S	IGNE	D		-				_
			_			-				
PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful s material fact, knowing it to be false.	submiss	ion c	of an	y sta	teme	nt oı	· evid	ence	of a	ı
PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than 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	rcement	t, cor	ngres	ssion	al co	mmı	unica	tions		

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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Claimant Email:

Representative Email: