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 to for the Deaf (TDD), the Federal relay nu			•				evice	•							
SECTION I - VETERAN'S IDENTIFICATION INFORMATION															
NOTE: You may complete the form onli per box, and completely fill in each appli						nation req	ueste	d in	ink, nea	ly and	d legibl	y, inse	ert one	lette	er
1. VETERAN'S NAME (First, Middle Initial, La	ast)														
Jane Doe															
2. SOCIAL SECURITY NUMBER		3. VA FILE N	UMBER	(If applica	ıble)		4	. DA	TE OF BI	RTH (I	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 app	plicable)						·								
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															
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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															
5 5 5 — 8 0 0 — 1 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, La	ast)														
10. SOCIAL SECURITY NUMBER (If applica	able)		11	. DATE O	F BIRTI	H (MM/DD/	YYYY)	(If a	oplicable)						
12. CURRENT MAILING ADDRESS (Numbe	er, street or rural rout	te, City or P.O	. Box, St	tate and Z	IP Code	and Count	ry)			4					
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State/Province Country	,	ZIP Code/	Postal C	ode				_	•						
13. TELEPHONE NUMBER (Include Area Co	ode)														
		Enter	Internat	tional Pho	ne Num	ber (If appli	cable)								
14. E-MAIL ADDRESS (Optional)															
		SECTIO													
15. SELECT ONLY ONE (If you file for multip			•				ach be	nefit	. ,	NIC !!		A D& 414	C.T.D. ^	TION	
 COMPENSATION PENSION/S VETERAN READINESS AND EMPLO 	SURVIVORS BENEF DYMFNT	_	OUCIARY AN GUA		~	UCATION E INSURAI	NCF		VETER/ NATION						
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SECTION IV - OPTIONAL INFORMAL CONFERENCE	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.)										1
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:	schedu	ule the	e infor	rmal c	onfer	ence.	. Coi	ntact	attem	pts
Call me between 8:00 a.m 12:00 p.m. ET Call me between 12:00	p.m	4:30	p.m. E	ĒΤ						
Call my representative between 8:00 a.m 12:00 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	CON	TACT	ΓINF	ORMA	1OITA	N BE	LOW	•	
Helen Holly										
17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code)										
+6-555-800-11	11									
17C. REPRESENTATIVE'S E-MAIL ADDRESS						7				
SECTION V. SOCIESOS ORT IN FROM LECACY ARREALS SYSTEM										
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				a Sta	ateme	nt of	the C	Case	(SOC) or
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	assoc	ciated	heari	ng re	ques	ts, fro	m th	è
OPT-IN FROM SOC/SSOC										
NOTE: Add the date of the SOC or SSOC in block 19B for all appeal issues being withdrawn.	-\A/									
SECTION VI - ISSUES FOR HIGHER-LEVEL REVIE 19. INDICATE EACH ISSUE DECIDED BY VA FOR WHICH YOU ARE REQUESTING A HIGHER-LEVEL REVIEW. Re		your d	lecisio	on not	tice(s)) for a	list	of adj	udica	ted
issues. For each issue, identify the date of VA's most recent decision on the issue. You may attach additional sheet each additional sheet. IMPORTANT: You may only list issues for the benefit type selected in Section III. A separa	s, if ne	cessa	ıry - in	nclude	your	nam	e and	d file		
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19	9B. D	ATE (A DEC				CATI	NC
Example 1: Service connection for left knee		DD/YY								
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	MM/E	OD/YY OD/YY OD/YY	ΥY							
Example 5: Entitlement to Service-Disabled Veterans Insurance		DD/YY								
	SO	C/S	SOC	! Da	ate	: 0	8-	01-	-20	20
tinnitus	0	1	_	0	1	_[1	9	0	0
								- 1		
left knee	0	1	-	0	2	_	1	9	0	0
might Imag	0	1	_	0	3	_[1	9	0	0
right knee		-				L				
PTSD	0	1	-	0	4	-[1	9	0	0
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Traumatic Brain Injury	0	1	_	0	5	_	1	9	0	0
right shoulder	0	1	_	0	6	-[1	9	0	0
						Г	1	I	- 1	
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SECTION VI - ISSUES FOR HIGHER-LEVEL REVIEW (Co	ntinued)									
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)									
SECTION VII - CERTIFICATION AND SIGNATURE										
NOTE: This section is MANDATORY and completion is required to process your claim unless accompan Certification or Section VIII is completed.	nied by VA Form 21-0972, Alternate Signer									
I CERTIFY the statements on this form are true and correct to the best of my knowledge and belief.										
1	20B. DATE SIGNED									
Jane Z Doe - Signed by digital authentication to api.va.gov	0 1 - 0 1 - 2 0 2 0									
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	a valid VA Form 21-22, Appointment of Veterans									
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.										
21A NAME OF VA ALITHODIZED DEDDESENTATIVE (First Lost)										
21A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)										
	NO. DATE CIONED									
	21C. DATE SIGNED									
	P1C. DATE SIGNED									
21B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink) PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful s material fact, knowing it to be false. PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than	submission of any statement or evidence of a what has been authorized under the Privacy									
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www.reginfo.gov/public/do/PRAMain.

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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