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.ya.gov/yaforms.

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							
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)								
josie@example.com								
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. &	T							
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 O PENSION/SURVIVORS BENEFITS O FIDUCIARY O EDUCATION O VETERANS HEALTH ADMINISTRATION O VETERANS HEALTH ADMINISTRATION O VETERAN READINESS AND EMPLOYMENT O LOAN GUARANTY O LIFE INSURANCE O NATIONAL CEMETERY ADMINISTRAT								
C LOAN GUARANTI C LIL LINGUIANCE CHIETERY ADMINISTRAT	1014							

VA FORM **20-0996**

SECTION IV - OPTIONAL INFORMAL CONFERI	ENCE							
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 may delay a decision.								
16B. IF YOU SELECTED THE BOX ABOVE, VA will make two attempts to contact you OR your representative to schedule the informal conference. Contact attempts will be between the hours of 8:00 a.m. and 4:30 p.m. Eastern Time. INDICATE ONE PREFERENCE:								
Call me between 8:00 a.m 12:00 p.m. ET Call me between 1	2:00 p.m 4:30 p.m. ET							
Call my representative between 8:00 a.m 12:00 p.m. ET Call my representative 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.	NTATIVE'S CONTACT INFORMATION BELOW.							
17A. REPRESENTATIVE'S NAME (First, Last)								
Helen								
17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code) 5 5 5 - 8 0 0 - 1 1 1 1 1 x2 17C. REPRESENTATIVE'S E-MAIL ADDRESS								
hholly@example.com								
SECTION V - SOC/SSOC OPT-IN FROM LEGACY APPE	ALS SYSTEM							
18. By marking the circle below, I ELECT TO PARTICIPATE IN THE MODERNIZED REVIEW SYSTEM for the follow Supplemental Statement of the Case (SSOC). I am withdrawing the eligible appeal issues listed in 19A in their elegacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn. T OPT-IN FROM SOC/SSOC NOTE: Add the date of the SOC or SSOC in block 10R for all appeal, issues being withdrawn.	entirety, and any associated hearing requests, from the							
NOTE: Add the date of the SOC or SSOC in block 19B for all appeal issues being withdrawn. SECTION VI - ISSUES FOR HIGHER-LEVEL RE	WEW							
19. INDICATE EACH ISSUE DECIDED BY VA FOR WHICH YOU ARE REQUESTING A HIGHER-LEVEL REVIEW								
issues. For each issue, identify the date of VA's most recent decision on the issue. You may attach additional seach additional sheet. IMPORTANT : You may only list issues for the benefit type selected in Section III. A separate of the second of the s	parate form is required for each benefit type.							
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)							
Example 1: Service connection for left knee 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 Example 5: Entitlement to Service-Disabled Veterans Insurance	MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY 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							
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							
Tell ear								
right ear	0 1 - 0 5 - 1 9 0 0							
11giic ear								
migraines	0 1 - 0 6 - 1 9 0 0							
left knee	0 1 - 0 7 - 1 9 0 0							
TETC VITEE								

VA FORM 20-0996, APR 2021

SECTION VI - ISSUES FOR HIGHER-LEVEL REVIEW (Continued)										
19A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	19B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)									
	0	1		0	8	Γ	1	9	0	0
right knee	U	1	_	U	0		<u> </u>	9	U	<u>U</u>
left foot	0	1	_	0	9	-[1	9	0	0
	80	c / c	SOC	ים י	a+ 0		∩1_	ΛQ_	20	21
			1			. (
right foot	0	1	_	1	0	<u>-</u>	1	9	0	0
left hand	0	1	1_	1	1	1_1	1	9	0	0
Tert hand		<u> </u>			<u>'</u>		•	•		
right hand	0	1]_	1	2	_	1	9	0	0
			-							
			_							
fever	0	1	<u> </u>	1	3	_	1	9	0	0
SECTION VII - CERTIFICATION AND SIGNATURE	E									
NOTE: This section is MANDATORY and completion is required to process your claim unless accompaning <i>Certification</i> or Section VIII is completed.	nied by	VA F	orm	21-0	972,	Alte	rnate	e Sigi	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) Jane Z Doe										
- Signed by digital authentication to api.va.gov		1	<u> </u>	0	1	_[2	0	2	0
SECTION VIII - AUTHORIZED REPRESENTATIVE SIGN	IATUR	RE								
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 '	VA F	orm 2	21-22 ntati	2, Ap	<i>poin</i>	tmer	nt of \ the	/eter	rans
appropriate representative is of record with VA or included with this application.			J, 000	, i di	,	Idioa	ung			
21A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)										
21B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink)		21C. DATE SIGNED								
			_			-				
PENALTY: The law provides severe penalties which include a fine, imprisonment, or both, for the willful s material fact, knowing it to be false.	submis	sion	of an	y sta	teme	nt or	revio	dence	e of a	3
PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than	what h	as b	een a	utho	rized	und	ler th	ne Pri	vacy	,

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.

VA FORM 20-0996, APR 2021 Page 5

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	