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

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

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 https://www.va.gov/find-forms/.

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)
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2. SOCIAL SECURITY NUMBER
WWW – WW – WWWW

3. VA FILE NUMBER (If applicable)
WWWWWWWWWW

4. DATE OF BIRTH (MM/DD/YYYY)
12 – 31 – 1969

5. VA INSURANCE POLICY NUMBER (If applicable)
WWWWWWWWWWWWWWWWWW

6. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)
No. & Street: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWW
Apt./Unit Number:
City: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW
State/Province: NY
Country: US
ZIP Code/Postal Code: WWWWWWWWWWWWWWWWW –

(●) I AM HOMELESS OR AT RISK OF HOMELESSNESS

7. TELEPHONE NUMBER (Include Area Code)
– –
Enter International Phone Number (If applicable): +WWW-WWWWWWWWWWWWWWWW

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)
WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW W WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW

10. SOCIAL SECURITY NUMBER (If applicable)
WWW – WW – WWWW

11. DATE OF BIRTH (MM/DD/YYYY) (If applicable)
05 – 08 – 1972

12. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)
No. & Street: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWW
Apt./Unit Number:
City: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW
State/Province: MI
Country: US
ZIP Code/Postal Code: WWWWWWWWWWWWWWWWW –

13. TELEPHONE NUMBER (Include Area Code)
– –
Enter International Phone Number (If applicable): +WWW-WWWWWWWWWWWWWWWW

14. E-MAIL ADDRESS (Optional)
See attached page for claimant email

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/DIC/SURVIVORS BENEFITS ( ) FIDUCIARY (●) EDUCATION ( ) VETERANS HEALTH ADMINISTRATION
( ) VETERAN READINESS AND EMPLOYMENT ( ) LOAN GUARANTY ( ) LIFE INSURANCE ( ) NATIONAL CEMETERY ADMINISTRATION

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 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 12:00 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'S CONTACT INFORMATION BELOW.

17A. REPRESENTATIVE'S NAME (First, Last)

WWWWWWWWWWWWWWWWWWWWWWWWWWWWWW | WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW

17B. REPRESENTATIVE'S TELEPHONE NUMBER (Include Area Code)

___ - ___ - ____ +WWW-WWWWWWWWWWWWWWWW

17C. REPRESENTATIVE'S E-MAIL ADDRESS

See attached page for representative email

SECTION V - ISSUES FOR HIGHER-LEVEL-REVIEW

18. If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By submitting this form, I agree to participate in the modernized review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed in 18A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn.

INDICATE EACH ISSUE DECIDED BY VA FOR WHICH YOU ARE REQUESTING A HIGHER-LEVEL REVIEW. Refer to your decision notice(s) for a list of adjudicated issues. For each issue, identify the date of VA's most recent decision on the issue. You may attach additional sheets, if necessary - include your name and file number on each additional sheet. IMPORTANT: You may only list issues for the benefit type selected in Section III. A separate form is required for each benefit type.

18A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	18B. 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
123456789 Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	SOC/SSOC Date: 04-30-2020 01-01-1900
left eyee Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-02-1900
right eye Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-03-1900
left ear Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	SOC/SSOC Date: 05-15-2019 01-04-1900
right ear Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-05-1900
migraines Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-06-1900
left knee Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-07-1900

SECTION V - ISSUES FOR HIGHER-LEVEL REVIEW (Continued)

18A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	18B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)
right knee Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-08-1900
left foot Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-09-1900
right foot Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	SOC/SSOC Date: 01-08-2021 01-10-1900
left hand Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-11-1900
right hand Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-12-1900
fever Area of Disagreement: WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	01-13-1900

SECTION VI - CERTIFICATION AND SIGNATURE

NOTE: This section is **MANDATORY** and completion is required to process your claim unless accompanied by VA Form 21-0972, *Alternate Signer Certification* or Section VII is completed.

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

19A. SIGNATURE OF VETERAN OR CLAIMANT (Sign in ink)	19B. DATE SIGNED
WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWWW	02-03-2021

SECTION VII - 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 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 representative is of record with VA or included with this application.

20A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)

20B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink)	20C. DATE SIGNED
	- -

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.

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.**

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Claimant Email:
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Representative Email:
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Additional Issues

A. Specific Issue(s)	B. Area of Disagreement	C. Date of Decision	D. SOC/SSOC Date
lupus	WWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWW	1900-01-14	09-23-2020
cooties	WWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWWWWWWWWWWWWWWWWWWWW WWWWWWWWW	1900-01-15	