

Department of Veterans Affairs		VA DATE STAMP DO NOT WRITE IN THIS SPACE
<b>DECISION REVIEW REQUEST: HIGHER-LEVEL REVIEW</b>		
<b>INSTRUCTIONS:</b> 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 <a href="http://www.va.gov/vaforms">www.va.gov/vaforms</a> .		
<b>SECTION I - VETERAN'S IDENTIFICATION INFORMATION</b>		
<b>NOTE:</b> 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)		
Jãñe		ø Doé
2. SOCIAL SECURITY NUMBER		3. VA FILE NUMBER (If applicable)
1 2 3 - 4 5 - 6 7 8 9		9 8 7 6 5 4 3 2
4. DATE OF BIRTH (MM/DD/YYYY)		
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 N Y Country U S ZIP Code/Postal Code 30012 -		
<input checked="" type="radio"/> 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)		
bob@bobbytablesemail.com		
<b>SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION (If other than veteran)</b>		
9. CLAIMANT'S NAME (First, Middle Initial, Last)		
Betty		D Boop
10. SOCIAL SECURITY NUMBER (If applicable)		11. DATE OF BIRTH (MM/DD/YYYY) (If applicable)
8 2 9 - 3 4 - 7 5 6 1		0 5 - 0 8 - 1 9 7 2
12. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)		
No. & Street 456 First St Apt 5 Box 1		
Apt./Unit Number City Detroit		
State/Province M I Country U S ZIP Code/Postal Code 48070 -		
13. TELEPHONE NUMBER (Include Area Code)		
5 5 5 - 8 1 1 - 1 1 0 0 Enter International Phone Number (If applicable)		
14. E-MAIL ADDRESS (Optional)		
claimant@email.com		
<b>SECTION III - BENEFIT TYPE</b>		
15. <b>SELECT ONLY ONE</b> (If you file for multiple benefit types, you must complete a separate VA Form 20-0996 for each benefit type.)		
<input type="radio"/> COMPENSATION <input type="radio"/> PENSION/SURVIVORS BENEFITS <input type="radio"/> FIDUCIARY <input checked="" type="radio"/> EDUCATION <input type="radio"/> VETERANS HEALTH ADMINISTRATION		
<input type="radio"/> VETERAN READINESS AND EMPLOYMENT <input type="radio"/> LOAN GUARANTY <input type="radio"/> LIFE INSURANCE <input type="radio"/> 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)

Helen

Holly

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

5 5 5 - 8 0 0 - 1 1 1 1 x2

17C. REPRESENTATIVE'S E-MAIL ADDRESS

holly@hellohellenholly.com

## SECTION V - SOC/SSOC OPT-IN FROM LEGACY APPEALS SYSTEM

18. By marking the circle below, I ELECT TO PARTICIPATE IN THE MODERNIZED REVIEW SYSTEM for the following issues decided in a Statement of the Case (SOC) or Supplemental Statement of the Case (SSOC). I am withdrawing the eligible appeal issues listed in 19A 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. TO OPT-IN, THE CIRCLE BELOW **MUST** BE MARKED.

☒ 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 REVIEW

19. 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.

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

123456789

SOC/SSOC Date: 04-30-2020

Area of Disagreement: Rating  
left eye

0 1 - 0 1 - 1 9 0 0

Area of Disagreement: 123456789  
right eye

0 1 - 0 2 - 1 9 0 0

left ear

0 1 - 0 3 - 1 9 0 0

Area of Disagreement: Rating  
right ear

SOC/SSOC Date: 05-15-2019  
0 1 - 0 4 - 1 9 0 0

Area of Disagreement: Rating  
migraines

0 1 - 0 5 - 1 9 0 0

Area of Disagreement: Rating  
left knee

0 1 - 0 6 - 1 9 0 0

Area of Disagreement: Rating

0 1 - 0 7 - 1 9 0 0

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**Additional Issues**

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