OMB Control No. 2900-0219
Respondent Burden: 10 Minutes
Expiration Date: 10/31/2024

Department of Veterans Affairs

APPLICATION FOR CHAMPVA BENEFITS

Champ VA Program Office, Office of Integrated Veteran Care, CHAMPVA Eligibility, PO Box 469028, Denver CO 80246-9028
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7809

ATTENTION: Please refer to the information on the following pages for assistance completing this form in its entirety (print or type only). Return the form and any additional, requested information to the address shown above. If applicants indicate in Section II that they have Medicare or other health insurance, each applicant must submit VA Form 10-7959c, *CHAMPVA Other Health Insurance (OHI) Certification*. If additional space is needed, complete another VA Form 10-10d in its entirety, sign and submit.

SECTION I - SPONSOR INFORMATION

VETERAN'S LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	VA FILE NUMBER *(Claim Number)*
STREET ADDRESS	CITY		STATE	ZIP CODE
PHONE NUMBER *(Include Area Code)*	DATE OF BIRTH *(MM/DD/YYYY)*		DATE OF MARRIAGE *(MM/DD/YYYY)*	
IS THE VETERAN DECEASED? ☐ YES ☐ NO	*IF "YES," CONTINUE IF "NO," GO TO SECTION II*	DATE OF DEATH *(MM/DD/YYYY)*	DID THE VETERAN DIE WHILE ON ACTIVE MILITARY SERVICE? ☐ YES ☐ NO	

SECTION II - APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
STREET ADDRESS	CITY		STATE	ZIP CODE
EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*			GENDER ☐ MALE ☐ FEMALE
☐ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*		
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
STREET ADDRESS	CITY		STATE	ZIP CODE
EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*			GENDER ☐ MALE ☐ FEMALE
☐ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*		
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(MM/DD/YYYY)*
STREET ADDRESS	CITY		STATE	ZIP CODE
EMAIL ADDRESS	PHONE NUMBER *(Include Area Code)*			GENDER ☐ MALE ☐ FEMALE
☐ ENROLLED IN MEDICARE *If checked, complete VA Form 10-7959c and attach a copy of Medicare Card*	☐ HAS OTHER HEALTH INSURANCE *If checked, complete VA Form 10-7959c and attach a copy of insurance card*	RELATIONSHIP TO VETERAN *(i.e., spouse, child)*		

SECTION III - CERTIFICATION

I declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001. *(Sign and date below.)*

SIGNATURE:	DATE *(MM/DD/YYYY)*

If certification is signed by a person other than an applicant, complete the following:

LAST NAME	FIRST NAME	MI	RELATIONSHIP TO APPLICANT(S)	
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER *(Include Area Code)*