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 VA DATE STAMP DO NOT WRITE IN THIS SPACE

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="https://www.va.gov/find-forms/">https://www.va.gov/find-forms/</a> .									
SECTION I - VETERAN'S IDENTIFICATION INFORMATION									
<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)									
Jäñe Ø Doé									
AL SECURITY NUMBER 3. VA FILE NUMBER (If applicable) 4. DATE OF BIRTH (MM/DD/YYYY)									
1     2     3     -     4     5     -     6     7     8     9     987654321           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									
21.472 : N. V. 2.4. 11.0. 7722.472.422.4									
State/Province NY Country US ZIP Code/Postal Code 30012 —									
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									
SECTION II - CLAIMANT'S IDENTIFICATION INFORMATION (If other than veteran)									
9. CLAIMANT'S NAME (First, Middle Initial, Last)									
Betty 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									
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)									
Enter International Phone Number (If applicable) 555-811-1100 ext 4									
14. E-MAIL ADDRESS (Optional)									
claimant@email.com									
SECTION III - BENEFIT TYPE									
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.)  COMPENSATION PENSION/DIC/SURVIVORS BENEFITS FIDUCIARY  EDUCATION VETERANS HEALTH ADMINISTRATION									
COMPENSATION PENSION/DIC/SURVIVORS BENEFITS FIDUCIARY EDUCATION VETERANS HEALTH ADMINISTRATION  VETERAN READINESS AND EMPLOYMENT LOAN GUARANTY LIFE INSURANCE NATIONAL CEMETERY ADMINISTRATION									
(A FORM									

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 will be between the hours of 8:00 a.m. and 4:30 p.m. Eastern Time. INDICATE ONE PREFERENCE:	schedule the informal conference. Contact attempts					
Call me between 8:00 a.m 12:00 p.m. ET	) p.m 4:30 p.m. ET					
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 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 - ISSUES FOR HIGHER-LEVEL-REVIE						
18. If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By subm review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s)	in 18A in their entirety, and any associated hearing					
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	SOC/SSOC Date: 04-30-2020					
Area of Disagreement: Rating	0 1 - 0 1 - 1 9 0 0					
left eyee						
Area of Disagreement: 123456789	0 1 - 0 2 - 1 9 0 0					
right eye						
	0 1 - 0 3 - 1 9 0 0					
left ear	SOC/SSOC Date: 05-15-2019					
Area of Disagreement: Rating	0 1 - 0 4 - 1 9 0 0					
right ear						
Area of Disagreement: Rating	0 1 - 0 5 - 1 9 0 0					
migraines						
Area of Disagreement: Rating	0 1 - 0 6 - 1 9 0 0					
left knee						
Area of Disagreement: Rating	0 1 - 0 7 - 1 9 0 0					

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SECTION V - ISSUES FOR HIGHER-LEVEL REVIEW (Co	ontinued	d)							
18A. SPECIFIC ISSUE(S) OF DISAGREEMENT (REQUIRED)	18B. DATE OF VA DECISION NOTIFICATION LETTER (REQUIRED)								
right knee									
Area of Disagreement: Rating	0	1 _	0	8	-[	1	9	0	0
left foot									
Area of Disagreement: Rating	0	1 _	0	9	_	1	9	0	0
right foot	SOC/SSOC Date: 01-08-2021				:1				
Area of Disagreement: Rating	0	1 _	1	0	_[	1	9	0	0
left hand									
Area of Disagreement: Rating	0	1 _	1	1	]_	1	9	0	0
right hand									
Area of Disagreement: Rating	0	1 –	1	2	_	1	9	0	0
fever									
Area of Disagreement: Service connection	0	1 _	1	3	]_	1	9	0	0
SECTION VI - CERTIFICATION AND SIGNATURI	E								
<b>NOTE:</b> This section is <b>MANDATORY</b> and completion is required to process your claim unless accompar <i>Certification</i> or Section VII is completed.	nied by V	A Form	21-0	1972,	Alte	rnate	e Sig	ner	
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. DAT	TE SIGN	ED						
Betty D Boop - Signed by digital authentication to api.va.gov	0	2 _	0	3	-	2	0	2	1
SECTION VII - AUTHORIZED REPRESENTATIVE SIGN	ATURE								
I CERTIFY the statements on this form are true and correct to the best of my knowledge and belief.									
<b>NOTE</b> : 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 Claim appropriate representative is of record with VA or included with this application.								Vete	rans
20A. NAME OF VA AUTHORIZED REPRESENTATIVE (First, Last)									
20B. SIGNATURE OF VA AUTHORIZED REPRESENTATIVE (Sign in ink)	20C. DAT	E SIGNI	D						
					-				
<b>PENALTY:</b> The law provides severe penalties which include a fine, imprisonment, or both, for the willful smaterial fact, knowing it to be false.	submissio	on of ar	y sta	teme	nt or	r evi	denc	e of a	а

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 <a href="https://www.reginfo.gov/public/do/PRAMain.">www.reginfo.gov/public/do/PRAMain.</a>

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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	