

OMB Control No. 2900-0886
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: SUPPLEMENTAL CLAIM		
INSTRUCTIONS: PLEASE READ THE PRIVACY ACT NOTICE AND RESPONDENT BURDEN INFORMATION ON PAGE 2 BEFORE COMPLETING THIS FORM.		
PART I - CLAIMANT'S IDENTIFYING INFORMATION		
NOTE: You can either complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing the form.		
1. VETERAN'S NAME (First, Middle Initial, Last)		
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2. VETERAN'S SOCIAL SECURITY NUMBER		
1 2 3 - 4 5 - 6 7 8 9		
3. VA FILE NUMBER (If applicable)		
9 8 7 6 5 4 3 2 1		
4. VETERAN'S DATE OF BIRTH (MM/DD/YYYY)		
Month Day Year 1 2 - 3 1 - 1 9 6 9		
5. VETERAN'S SERVICE NUMBER (If applicable)		
6. INSURANCE POLICY NUMBER (If applicable)		
9 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 9		
7. CLAIMANT'S NAME (First, Middle Initial, Last) (If other than veteran)		
8. CLAIMANT TYPE:		
<input checked="" type="checkbox"/> VETERAN <input type="checkbox"/> VETERAN'S SPOUSE <input type="checkbox"/> VETERAN'S CHILD <input type="checkbox"/> VETERAN'S PARENT <input type="checkbox"/> OTHER (Specify)		
9. CURRENT MAILING ADDRESS (Number, street or rural route, City or P.O. Box, State and ZIP Code and Country)		
No. & Street 123 Main St		
Apt./Unit Number City New York		
State/Province Country U S ZIP Code/Postal Code 30012 -		
10. TELEPHONE NUMBER (Include Area Code)		
5 5 5 - 8 0 0 - 1 1 1 1 International Phone Number (If applicable)		
11. E-MAIL ADDRESS (Optional)		
josie@example.com		
12. BENEFIT TYPE: PLEASE CHECK ONLY ONE (If you would like to file for multiple benefit types, you must complete a separate request form for each benefit type.)		
<input type="checkbox"/> COMPENSATION <input type="checkbox"/> PENSION/DIC/SURVIVORS BENEFITS <input checked="" type="checkbox"/> FIDUCIARY <input type="checkbox"/> LIFE INSURANCE <input type="checkbox"/> VETERANS HEALTH ADMINISTRATION <input type="checkbox"/> VETERAN READINESS AND EMPLOYMENT <input type="checkbox"/> LOAN GUARANTY <input type="checkbox"/> EDUCATION <input type="checkbox"/> NATIONAL CEMETERY ADMINISTRATION		
PART II - ISSUE(S) FOR SUPPLEMENTAL CLAIM		
13. YOU MUST LIST EACH ISSUE DECIDED BY VA THAT YOU WOULD LIKE VA TO REVIEW AS PART OF YOUR SUPPLEMENTAL CLAIM. Please refer to your decision notice(s) for a list of adjudicated issues. For each issue, please identify the date of VA's decision. (You may attach additional sheets of paper, if necessary. Include your name and file number on each additional sheet.)		
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 13A 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.		
13A. SPECIFIC ISSUE(S)		13B. DATE OF VA DECISION NOTICE
right shoulder		1900-01-06

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