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

123 – 45 – 6789

3. VA FILE NUMBER *(If applicable)*

987654321

4. VETERAN'S DATE OF BIRTH *(MM/DD/YYYY)*

Month 12 – Day 31 – Year 1969

5. VETERAN'S SERVICE NUMBER *(If applicable)*

6. INSURANCE POLICY NUMBER *(If applicable)*

9876543211234567 89

7. CLAIMANT'S NAME *(First, Middle Initial, Last) (If **other** than veteran)*

8. CLAIMANT TYPE:

☒ VETERAN ☐ VETERAN'S SPOUSE ☐ VETERAN'S CHILD ☐ VETERAN'S PARENT ☐ 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: US

ZIP Code/Postal Code: 30012 –

10. TELEPHONE NUMBER *(Include Area Code)*

555 – 800 – 1111 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.)*

☐ COMPENSATION ☐ PENSION/DIC/SURVIVORS BENEFITS ☒ FIDUCIARY ☐ LIFE INSURANCE ☐ VETERANS HEALTH ADMINISTRATION
☐ VETERAN READINESS AND EMPLOYMENT ☐ LOAN GUARANTY ☐ EDUCATION ☐ 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

PART III - NEW AND RELEVANT EVIDENCE

14. To complete your application, you must submit new and relevant evidence to VA or tell us about new and relevant evidence that VA can assist you in gathering in support of your supplemental claim. If you have records in your possession, please attach the records to this form. Please list your name and file number on each page. If you would like VA to obtain **non-federal records,** please review your decision notification letter for the appropriate authorization forms to complete and submit those forms to VA with this request form.

15. DO YOU WANT VA TO GET FEDERAL RECORDS?

LIST BELOW ANY **VA MEDICAL CENTER(S) (VAMC), VA TREATMENT FACILITIES, OR FEDERAL DEPARTMENTS OR AGENCIES** THAT HAVE NEW AND RELEVANT EVIDENCE THAT YOU ARE AUTHORIZING VA TO OBTAIN IN SUPPORT OF YOUR SUPPLEMENTAL CLAIM: *You may attach additional sheets of paper, if necessary. Please list your name and file number on each additional sheet.*

15A. NAME AND LOCATION	15B. DATE(S) OF RECORDS
Veteran indicated they will send evidence documents to VA.	

PART IV - 5103 NOTICE ACKNOWLEDGMENT
(This section applies to Compensation, Pension, DIC, and Accrued benefit claims only)

NOTE: If we issued your decision within the past year, you can skip this section.

16. Find out what evidence you'll need to provide by visiting one these pages on VA.gov:
- Evidence to support a claim for Veteran's Disability and related Compensation benefits: www.va.gov/disability/how-to-file-claim/evidence-needed
- Evidence to support a claim for VA pension, DIC, or accrued benefits: www.va.gov/resources/evidence-to-support-va-pension-dic-or-accrued-benefits-claims/

CERTIFY THAT I have reviewed the notice of evidence that relates to my claim.

☐ YES

☐ NO (If you check "NO," VA will send the 5103 notice to you via mail.)

PART V - CERTIFICATION AND SIGNATURE

NOTE: This section is **MANDATORY** and completion is required to process your claim, any omission may delay claim processing time.

VA AUTHORIZED REPRESENTATIVES ONLY: I certify that the claimant has authorized the undersigned representative to file this supplemental claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature ***will not*** be accepted unless at the time of submission of this claim 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 POA is of record with VA.

17A. SIGNATURE OF VETERAN OR CLAIMANT OR VA AUTHORIZED REPRESENTATIVE *(Sign in ink)*	17B. DATE SIGNED
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17C. NAME OF VA AUTHORIZED REPRESENTATIVE *(Please Print)*

ALTERNATE SIGNER CERTIFICATION AND SIGNATURE

18. **I CERTIFY THAT** by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

18A. SIGNATURE OF ALTERNATE SIGNER *(Sign in ink)*	18B. DATE SIGNED

18C. NAME OF ALTERNATE SIGNER *(Please Print)*

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.