OMB Approved No. 2900-0545
Respondent Burden: 45 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

REPORT OF MEDICAL, LEGAL, AND OTHER EXPENSES INCIDENT TO RECOVERY FOR INJURY OR DEATH

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Read the Privacy Act and Respondent Burden Information on Page 2 before completing the form.

NOTE: If you or a family member received compensation for injury, illness or death, you must report the date and amount of the recovery to VA. In most instances, the amount received will be countable income for VA purposes. However, the amount counted in determining your entitlement to VA benefits can be reduced by the amount of any unreimbursed expenses incurred in connection with the recovery. Use this form to report those expenses.

PART I - PERSONAL INDENTIFICATION INFORMATION

NOTE: You can ***either*** complete the form online or by hand. Please print information using blue or black ink, neatly, and legibly to help process the form.

1. VETERAN'S NAME *(First, Middle Initial, Last)*

2. VETERAN'S SOCIAL SECURITY NUMBER

3. VA FILE NUMBER

4. DATE OF BIRTH *(MM/DD/YYYY)*
Month Day Year

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

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

7. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street
Apt./Unit Number
City
State/Province
Country
ZIP Code/Postal Code

8. TELEPHONE NUMBER *(Include Area Code)*

9. EMAIL ADDRESS *(Optional)*

PART II - EXPLANATION OF EXPENSES

10. Report *all* medical, legal, and other expenses that you or a family member incurred incident to recovery for injury or death.

A. PURPOSE *(Legal Fees, Fees for Expert Witnesses, Medical Expenses Paid Before Date of Recovery, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID *(Mo/Day/Yr)*	D. NAME OF PROVIDER *(Doctor, Attorney, Consultant, etc.)*	E. COMPENSATION PAID BY *(RR Retirement Board, Civil Lawsuit, etc.)*

Veteran's SSN ___ – __ – ____

10. Report *all* medical, legal, and other expenses that you or a family member incurred incident to recovery for injury or death. *(Continued)*

A. PURPOSE *(Legal Fees, Fees for Expert Witnesses, Medical Expenses Paid Before Date of Recovery, etc.)*	B. AMOUNT PAID BY YOU	C. DATE PAID *(Mo/Day/Yr)*	D. NAME OF PROVIDER *(Doctor, Attorney, Consultant, etc.)*	E. COMPENSATION PAID BY *(RR Retirement Board, Civil Lawsuit, etc.)*

I CERTIFY THAT the above information is true.

11. SIGNATURE OF CLAIMANT *(Sign in ink)*	12. DATE SIGNED

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

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 required to obtain or retain benefits. The requested information is considered relevant and necessary to determine maximum benefits under the law. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

Respondent Burden: We need this information to determine eligibility to pension (38 U.S.C. 1503). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete this 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 **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.