NOTE: Instructions are written for a multi-part form. Print additional copies as necessary.

OMB No: 2900-0080
Estimated Burden: 15 min.

Department of Veterans Affairs

# CLAIM FOR PAYMENT OF COST OF UNAUTHORIZED MEDICAL SERVICES

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. Comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing the burden, may be addressed by calling the Health Benefits Contact Center at 1-877-222-8387.

**PRIVACY ACT INFORMATION:** The information requested on this form is solicited under authority of Title 38, United States Code, "Veterans Benefits," and will be used to assist us in determining your entitlement to reimbursement for services rendered. It will not be used for any other purpose. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your claim. Failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled. This form and relevant documents need to be sent to the VA Medical Facility where the Veteran is enrolled for medical care

## PART I

| 1A. VETERAN'S NAME (Last, first, middle initial) (This is a mandatory field.) | 1B. CLAIM NUMBER<br>C- | 1C. SOCIAL SECURITY NUMBER (Mandatory field.) |
|---|---|---|
| | | |

1D. VETERAN'S ADDRESS (Include complete ZIP Code)

| 2A. NAME AND ADDRESS OF PERSON, FIRM OR INSTITUTION MAKING CLAIM (Leave blank if same as above) | 2B. SOCIAL SECURITY NO. OR EMPLOYEE IDENTIFICATION NO. |
|---|---|
| | |

3. STATEMENT OF CIRCUMSTANCES UNDER WHICH THE SERVICES WERE RENDERED (Include diagnosis, symptoms, whether emergency existed, and reason VA facilities were not used)

| 4. AMOUNT CLAIMED<br>0.00 | Attach bills or receipts showing services furnished, dates and charges |
|---|---|

## 5. COMPLETE A OR B AS APPROPRIATE

| A. Amount charged does not exceed that charged the general public for similar services. Payment has not been received. | | B. I certify that the amount claimed has been paid and reimbursement has not been received. | |
|---|---|---|---|
| SIGNATURE AND TITLE OF PROVIDER OF SERVICE AND DATE | (mm/dd/yyyy) | SIGNATURE OF VETERAN OR REPRESENTATIVE AND DATE | (mm/dd/yyyy) |
| | | | |

## PART II - FOR VETERANS AFFAIRS USE ONLY

| 6. ACTION | | CLAIM MEETS THE REQUIREMENT OF VA REGULATION | |
|---|---|---|---|
| ☐ APPROVED $ | ☐ DISAPPROVED | ☐ 6080 | ☐ 6081 |

| 7. SIGNATURE OF CHIEF, MEDICAL ADMINISTRATION SERVICE | 8. DATE | 9. ADMINISTRATIVE VOUCHER NUMBER |
|---|---|---|
| | | |