OMB Number: 2900-0188
Estimated Burden: 4 minutes

Department of Veterans Affairs	PROSTHETIC SERVICE CARD INVOICE	VENDOR'S INVOICE NUMBER

This information is collected in accordance with section 3507 of the **Paperwork Reduction Act of 1995.** Accordingly, 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 providers who must complete this form will average 4 minutes. This includes the time to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to provide a means of billing for repairs authorized by VA Form 10-2501, Prosthetic Service Card. Although you must submit a bill to receive reimbursement, return of this form is voluntary. Failure to respond will have no adverse effect on benefits to which you might otherwise be entitled.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38, U.S.C., Veterans Benefits, and will be used to determine your eligibility/entitlement and reimbursement of individual claims, and identify your medical records. Additional information may be solicited during the course of processing your application. The information you supply may also be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" 24VA136, published in the Federal Register. Disclosure is voluntary, however, failure to furnish the information will result in our inability to process your request promptly and serve your medical needs. Failure to furnish the information will have no adverse effect on any other benefits to which you may be entitled.

TO	VETERANS AFFAIRS	FROM	NAME AND ADDRESS OF FIRM OR DEALER

VETERAN'S NAME (Last, first, middle initial) *(mandatory)*	VETERAN'S ADDRESS	LAST 4 DIGITS OF SSN (This is a mandatory field.)

NAME OF APPLIANCE MANUFACTURER	TYPE OF APPLIANCE	DATE DELIVERED

SECTION I - HCPCS REPAIR DATA

INSTRUCTIONS - Itemize separately actual amount and charges for material and parts used in rendering repairs, GIVING COMPLETE DESCRIPTION (DIMENSIONS, ETC.) OF MATERIAL USED, HCPCS AND/OR SPECIFIC ITEM REPAIRED. Labor charges will not be included in cost of material or parts, and are to be listed separately. Indicate in the spaces provided hereon the name, type, and age of the appliance repaired.

NOTE: Payment will be deferred until these instructions are followed.

REPAIR DESCRIPTION	HCPCS	CHARGES
DATE OF SERVICE *(mm/dd/yyyy)*	**TOTAL CHARGES**	**$**

WARNING - Any abuse of this system by the vendor through excessive charges for repairs or by the veteran in aiding or abetting such irregular activities may result in discontinuation of the program and invocation of criminal statutes for frauds against the Government.

SECTION II - CERTIFICATION OF VETERAN

▶ I certify that this invoice has been completed to show total charges; that charges seem proper for work done; that these repairs were necessary and satisfactory	SIGNATURE OF VETERAN ***(DO NOT SIGN A BLANK FORM)***	DATE *(mm/dd/yyyy)*

SECTION III - TO BE COMPLETED BY VA PROSTHETICS SERVICE

VA FORM 10-2501 IS OF RECORD IN THIS CASE. PAYMENT AS CLAIMED IS RECOMMENDED, WITH THE FOLLOWING EXCEPTIONS: ☐ None ☐ See Reverse	SIGNATURE AND TITLE	DATE *(mm/dd/yyyy)*

APPROVED FOR	PURCHASE ORDER NUMBER	DATE *(mm/dd/yyyy)*