



Attention: After reviewing the following information, complete the form in its entirety (print or type only), and return with the required documentation itemized billing statements to the Department of Veterans Affairs, Financial Services Center, PO Box 149200, Austin TX, 78714-9200. Customer Service Center: 1-866-372-1144, Fax: 512-460-5536.

Claim form usage: This form is to be completed by the patient, sponsor, or guardian and is mandatory for all beneficiary claims. This claim form is NOT to be used for provider submitted claims.

Other health insurance (OHI): If OHI exists, attach OHI's Explanation of Benefits (EOB) to the provider's itemized billing statement(s). Dates of service and provider charges on EOB must match billing statements.

Timely filing requirement: Claims must be received no later than two years after the date of service or, in the case of inpatient care, within two years of the discharge date.

Itemized billing statements: An itemized statement must be attached and contain:

- patient name, date of birth, and Member Number (same as patient's Social Security number);
- provider name, degree, tax identification number (TIN), address and telephone number; and
- service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e. CPT-4, HCPCS, and ICD-9-CM codes), including narrative descriptions. Pharmacy claims are to include name, quantity, strength, and NDC of each drug.

Section I - Patient Information

Last Name	First Name	MI	Social Security Number
Street Address		<input type="checkbox"/> Check this box if this is a new address	
Date of Birth (mm/dd/yyyy)			
City	State	Zip Code	Telephone Number (include area code)

Section II - Other Health Insurance (OHI) Information

By law, other coverage must be reported. If more space is needed, please continue in the same format on a separate sheet.

• Was treatment for a work-related injury or condition? <input type="checkbox"/> Yes <input type="checkbox"/> No • Was treatment for an injury or accident outside of work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Other Health Insurance (OHI)		
	OHI Policy Number		OHI Telephone Number (include area code)
• Are you covered by other primary health insurance to include coverage through a family member (supplemental or secondary insurance excluded)? <input type="checkbox"/> Yes (check type below and provide coverage information on the right) <input type="checkbox"/> employer sponsored (group) <input type="checkbox"/> private (non group) <input type="checkbox"/> Medicare (Part A or B) <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> no (proceed to Section III)	Name of Other Health Insurance (OHI)		
	OHI Policy Number		OHI Telephone Number (include area code)

Section III - Veteran Information

Last Name	First Name	MI	Social Security Number (optional)
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Section IV - Claimant Certification

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious, or fraudulent statements or claims.

I certify that the above information and attachments are correct and true to the best of my knowledge and belief. (Sign and date below.)

Signature (type if electronic)	Date
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If certification is signed by a person other than an applicant, complete the following:

Last Name	First Name	MI	Relationship to Applicant
Street Address			
City	State	ZIP Code	Telephone Number (include area code)

Camp Lejeune Family Member Program Claim Form (Continued)

The Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. The purpose of this data collection is to determine eligibility for benefits.

Privacy Act Information: The authority for collection of the requested information on this form is 38 USC 1787. The purpose of collecting this information is to determine your eligibility for reimbursement of health care related to conditions determined to result from contaminated water while you resided at Camp Lejeune, North Carolina, for a period of at least 30 days. The information you provide may be verified by computer matching programs with authoritative sources such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Department of Defense (DoD), Defense Enrollment Eligibility Reporting System (DEERS), Centers for Medicare & Medicaid Services (CMS) or any other applicable authoritative source at any time. You are requested to provide your social security number as your VA record is filed and retrieved by this number. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, given the form's purpose of establishing eligibility for the Camp Lejeune Family Member Program, it may delay or result in denial of your request for Camp Lejeune Family Member Program benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled. The responses you submit are considered private confidential and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records number 23VA16. For example, information including your social security number may be disclosed to the Department of Defense, contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services.