OMB Control Number: 2900-0219 Estimated Burden: 7 minutes Expiration Date: 10/31/2024

Department of Veterans Affairs — CHAMPVA Potential Liability Claim

Chief Business Office Purchased Care **CHAMPVA** **PO Box 469063** **Denver CO 80246-9063** **1-800-733-8387**

Attention: After reviewing the following information, complete this form (print or type only) in its entirety and return.

Purpose: Based on recent claim information, medical services have been received for the treatment of an injury or potential work-related illness. Because the Federal Medical Care Recovery Act, 42 USC 2651-2653, requires the recovery of VA costs associated with such services when the injury/illness was caused or is covered by a third party, the following information is required.

Section I - Patient Information

1. Last Name (this is a mandatory field)	2. First Name (this is a mandatory field)	MI	3. Social Security Number (this is a mandatory field)

4. Street Address	5. Date of Birth (mm/dd/yyyy)

6. City	7. State	8. ZIP Code	9. Telephone Number (include area code)

Section II - Injury/Illness Information

If more space is needed, continue in the same format on separate sheet

10. Diagnosis

11. Circumstances

a. When

b. Where ☐ Work ☐ Auto Accident ☐ Home ☐ Other (specify below)

12. Describe What Happened

13. Last Name of Witness

14. First Name of Witness **MI**

15. Witness Telephone Number (include area code)

16. Last Name of Investigator (i.e. police)

17. First Name of Investigator **MI**

18. Title

19. Investigator Telephone Number (include area code)

Section III - Third Party Claim Information

If more space is needed, continue in the same format on separate sheet

20. Based on location of incident in Section II, provide insurance information for:

☐ Auto Insurance ☐ Employer ☐ Home Owner Insurance ☐ Other (specify)

21. Name of Insurance Company/Employer

22. Street Address

23. City

24. State	25. ZIP Code	26. Insurance Co. / Employer Phone (include area code)

27. Insurance Policy Number

28. Is patient represented by an attorney or contemplating representation?

☐ Yes (complete attorney information below)

☐ No (proceed to Section IV)

29. Last Name of Attorney	30. First Name of Attorney

31. Street Address

32. City

33. State	34. ZIP Code	35. Attorney Telephone Number (include area code)

Section IV - Certification

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

36. I certify that the above information and attachments are correct to the best of my knowledge and belief. (Sign and date on right.) If signed by a person other than patient, complete the following.

Signature **Date**

37. Last Name	38. First Name	MI	39. Relationship to Patient

40. Street Address

41. City	42. State	43. ZIP Code	44. Telephone Number (include area code)

CHAMPVA Potential Liability Claim Form

Privacy Act Information: Information on this form is collected in accordance with the System of Records Notice 54VA10NB3, Veterans and Beneficiaries Purchased Care Community Health Care Claims, Correspondence, Eligibility, Inquiry and Payment Files-VA (Published March 3, 2015, FR 80, number 41). **Category:** Records maintained in the system include program applications, eligibility information concerning the Veteran, family members, caregivers, other health insurance information to include information regarding eligibility or entitlement to other federal medical programs. **Authority:** 38 USC 501 and 1781. **Purpose:** Records may be used for purposes of establishing and monitoring eligibility to receive VA benefits, processing claims for medical care and services, and processing stipends. **Routine Use:** The Privacy Act permits VA to disclose information about individuals without their consent under the Privacy Act Routine Use Disclosure when the information will be used for a purpose that is compatible with the purpose for which VA collected the information. **Disclosure:** Voluntary. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, it may delay or result in denial of your request for CHAMPVA benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled.

VA Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0219, and it expires 10/31/2024. Public reporting burden for this collection of information is estimated to average 7 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0219 in any correspondence. Do not send your completed VA Form 10-7959d to this email address. Questions regarding completion of this form may be addressed by calling the CHAMPVA Help Line at 1-800-733-8387. The Federal Medical Care Recovery Act, 42 USC 2651-2653, requires VA to recover costs associated with medical services received for treatment of an injury or potential work-related illness when the injury/illness was caused or is covered by a third party.