



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

Section III - Third Party Claim Information

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

10. Diagnosis		20. Based on location of incident in Section II, provide insurance information for: <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Home Owner Insurance <input type="checkbox"/> Other (specify)				
11. Circumstances		21. Name of Insurance Company/Employer				
a. When	b. Where <input type="checkbox"/> Work <input type="checkbox"/> Auto Accident <input type="checkbox"/> Home <input type="checkbox"/> Other (specify below)					
12. Describe What Happened		22. Street Address				
		23. City				
13. Last Name of Witness		24. State	25. ZIP Code		26. Insurance Co. / Employer Phone (include area code)	
14. First Name of Witness		MI	27. Insurance Policy Number			
15. Witness Telephone Number (include area code)		28. Is patient represented by an attorney or contemplating representation? <input type="checkbox"/> Yes (complete attorney information below) <input type="checkbox"/> No (proceed to Section IV)				
16. Last Name of Investigator (i.e. police)		29. Last Name of Attorney			30. First Name of Attorney	
17. First Name of Investigator		MI	31. Street Address			
18. Title		32. City				
19. Investigator Telephone Number (include area code)		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.