*US Department of Veterans Affairs*

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***Foreign Medical Program***

# Registration Form

**PLEASE COMPLETE THIS FORM AND SUBMIT IT TO THE FMP OFFICE AT THE ADDRESS LISTED BELOW OR BY FAX TO 303•331•7803. ALL ITEMS MUST BE COMPLETED (IF NOT APPLICABLE, PLEASE WRITE *NONE* OR *N/A*)**

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**(please print)**

**Name:** _____ _____ _____
**Last** **First** **Middle**

**US Social Security Number:** _____

**VA Claim/File Number:** _____

**Physical Address:**

_____

_____

_____

**Country:** _____

**Mailing Address:**

_____

_____

_____

**Country:** _____

**Telephone Number:** _____

**Facsimile (FAX) Number:** _____

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**(*Veteran's/Fiduciary's Signature*)** **(*Date*)**

**IF ELIGIBLE, AN *FMP BENEFITS AUTHORIZATION* FORM WILL BE ISSUED TO YOU AT YOUR ABOVE MAILING ADDRESS.**

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|---|---|---|---|
| **FMP Office** | **PO Box 65021** | **Denver CO 80206-9021** | **USA** |