



1. Veteran's Last Name		2. First Name		3. MI	4. Social Security Number
5. Permanent Street Address					
6. City		7. State		8. Zip Code	
9. Primary Phone Number			10. Alternate Phone Number		
11. Mailing Address (Address where check is to be mailed if different from Blocks 5-8)					
12. City		13. State		14. Zip Code	

INSTRUCTIONS

GENERAL: TO CLAIM A VA COPAYMENT - USAA / HARTFORD REFUND, PLEASE COMPLETE, SIGN, AND MAIL THIS APPLICATION TO:

DEPARTMENT OF VETERANS AFFAIRS
 HEALTH REVENUE CENTER
 ATTN: USAA / HARTFORD CLAIM PROCESSING
 3401 SW 21ST BLDG 9,
 TOPEKA KS 66604-3302.

NOTE: FAILURE TO INCLUDE ALL NECESSARY INFORMATION MAY RESULT IN DELAYED PROCESSING. ONLY CLAIMS FOR TREATMENT RECEIVED BETWEEN JANUARY 1, 1995 AND DECEMBER 31, 2001 WITH COVERAGE FROM EITHER THE USAA OR HARTFORD INSURANCE COMPANIES WILL BE CONSIDERED. PHARMACY CO-PAYMENTS ARE NOT ELIGIBLE FOR REFUND.

BLOCK 1-10: PRINT THE LAST NAME, FIRST NAME, MIDDLE INITIAL (MI), SOCIAL SECURITY NUMBER, PERMANENT ADDRESS, AND A PRIMARY AND ALTERNATE PHONE NUMBER OF THE VETERAN.

BLOCK 11-14: PRINT THE MAILING ADDRESS OF REFUND IF DIFFERENT FROM BLOCKS 5-8.

BLOCK 15a-c: PRINT THE VA FACILITY NAME, CITY, AND STATE WHERE TREATMENT WAS RECEIVED BY THE INSURED.

BLOCK 15d-h: PRINT THE TREATMENT PERIOD (MM/YY - MM/YY) AND THE NAME OF THE INSURED IF DIFFERENT FROM BLOCKS 1-3. SELECT THE INSURANCE CARRIER (CHECK THE APPROPRIATE BOX). PRINT THE INSURANCE POLICY NUMBER, TOTAL AMOUNT OF COPAYMENTS MADE BY THE VETERAN FOR VISITS.

BLOCK 16-17: COMPLETE INFORMATION IN THESE BLOCKS AS IN BLOCKS 15a-15h FOR ADDITIONAL FACILITIES WHERE TREATMENT WAS RECEIVED. IF THERE ARE MORE THAN THREE FACILITIES, COMPLETE ADDITIONAL CLAIM REQUESTS AS NECESSARY.

BLOCK 18-19: SIGN AND DATE THE APPLICATION. IF THE REQUEST IS SIGNED BY A REPRESENTATIVE OR EXECUTOR, PLEASE INCLUDE A COPY OF THE COURT APPOINTMENT OR POWER OF ATTORNEY.

15. VA Treatment Facility				
a. VA Treatment Facility Name		b. City	c. State	d. Treatment Period (MM/YY-MM/YY)
e. Name of Insured	f. Insurance Carrier <input type="checkbox"/> USAA <input type="checkbox"/> Hartford	g. Policy Number		h. Total of Veteran's Copayment
16. VA Treatment Facility				
a. VA Treatment Facility Name		b. City	c. State	d. Treatment Period (MM/YY-MM/YY)
e. Name of Insured	f. Insurance Carrier <input type="checkbox"/> USAA <input type="checkbox"/> Hartford	g. Policy Number		h. Total of Veteran's Copayment
17. VA Treatment Facility				
a. VA Treatment Facility Name		b. City	c. State	d. Treatment Period (MM/YY-MM/YY)
e. Name of Insured	f. Insurance Carrier <input type="checkbox"/> USAA <input type="checkbox"/> Hartford	g. Policy Number		h. Total of Veteran's Copayment

IF YOU HAVE QUESTIONS, PLEASE CALL OUR TOLL FREE NUMBER 1- (866) 258-2772

CERTIFICATION: I certify that the above entries are true and correct to the best of my knowledge and belief.

18. Signature of Claimant / Relationship		19. Date
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Department of Veterans Affairs

VA COPAYMENT REFUND - USAA / HARTFORD CLAIM FORM

Privacy Act Information: The information on this form is requested under the authority of 38 U.S.C. § 1710, which provides for VA's copayment charges to certain veterans for their non-service-connected VA medical care, and the provisions of a Settlement Agreement between VA and the Hartford and United Services Automobile Association (USAA) requiring that veterans insured by either carrier between the period from 1/1/1995 through 12/31/2001, be provided a one year opportunity to file claim with VA for a refund of their VA copayments from the proceeds of that settlement on a first-come, first-served basis until exhaustion of the settlement funds. The information is being collected solely to enable VA to determine your eligibility for a refund of your VA copayments under the USAA/Hartford settlement. The response you submit will be considered confidential, however, that information (name, address, insurance information), may be verified through a computer matching program. Any information on this form will be disclosed outside VA only as required by law and only if authorized under 38 U.S.C. § 5701, the Privacy Act, and the routine uses identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register, including, civil or criminal law enforcement, congressional communication, the collection of money owed to the United States, the administration of VA programs, and delivery of VA benefits, personnel administration, research or epidemiological studies, litigation in which the United States is a party or has an interest, and verification of identity and status. Your response, including Social Security number(s) pursuant to 38 U.S.C. § 5701, is voluntary; however, the information is required pursuant to the aforementioned settlement in order for us to determine your eligibility for the refund of the copayment(s) for which you are applying. Failure to furnish the information will have no adverse effect on any VA benefits to which you may be entitled.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to, this collection of information unless it displays a valid OMB Control Number. The 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. This form collects relevant information from veterans insured by USAA and Hartford who paid VA copayments for their VA care from 1/1/1995 through 12/31/2001, to determine their eligibility for refund from the proceeds of the USAA/Hartford settlement.

VA Form
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