

REQUEST FOR CHAMPVA BILLING
FOR CARE RELATED TO PERSONAL INJURY OR WORKERS COMPENSATION

INSTRUCTIONS

1. Complete the information for CHAMPVA to process your request. Failure to submit complete information may result in significant delays in processing your request.
 Attorney's Letter of Representation. If requested by, or on behalf of, a law firm/lawyer representing a party (includes record retrieval company for a law firm), include letter of representation with your request.
2. Click Print or Save. Buttons displayed in yellow at bottom of second page.
3. Send the request to CHAMPVA: VHA Community Care, P.O. Box 469062 741/04, Denver, CO 80246-9062. Fax # 303/398-5116

Beneficiary's Name (Last, First, Middle Initial)	
Beneficiary's Full Social Security Number	
Beneficiary's Mailing Address	
Beneficiary's Phone	
Describe Incident Resulting In Injury (Include Date and Location)	
Describe IN DETAIL Injuries Sustained / Nature of Disease DESCRIPTION MUST BE SPECIFIC	
List all <u>Facilities</u> Where Related Treatment Was Received	
Is Treatment Complete?	
If No, Describe Nature and Location of Ongoing Treatment	
Name of Beneficiary's Attorney	
Beneficiary's Attorney's Phone	
Beneficiary's Attorney's Mailing Address	
Beneficiary's Attorney's Email Address	
Beneficiary's Attorney's Fax	

BENEFICIARY'S INSURANCE - *USE MULTIPLE SHEETS FOR MORE THAN ONE INSURER*

Identify Applicable Insurers & Type <i>Examples: No Fault Insurance, Medical Payments from Veteran's Liability Insurance, Under-/Un-insured Motorist Insurance</i>	
Insurer's Mailing Address	
Insurer's Phone	
Insurer's Fax	
Insurer's Email	
Insurance Adjuster and Claim#	
Insurance POLICY LIMITS Description	

RESPONSIBLE PARTY (DEFENDANT) - *USE MULTIPLE SHEETS FOR MORE THAN ONE PARTY*

Name and contact information for Tortfeasor / Employer if Workers Compensation	
Name and contact information for Attorney representing Tortfeasor / Employer if Workers Compensation	
Identify Tortfeasor/Workers' Compensation Insurer	
Insurer's Mailing Address	
Insurer's Phone	
Insurer's Email	
Insurer's Fax	
Insurance Adjuster and Claim #	
Insurance POLICY LIMITS Description	
<i>Only if Workers' Compensation:</i> Name, Address, and Reference # for Workers' Compensation Board/Commission	