OMB Control No: 2900-0940
Estimated Burden: 10 min.
Expiration Date: 03/31/2027

Department of Veterans Affairs

VETERAN REIMBURSEMENT CLAIM FORM

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 current valid OMB control number. The OMB control number for this project is 2900-0940, and it expires 03/31/2027. Public reporting burden for this collection of information is estimated to average 10 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 and any other aspects for reducing the burden, to VA Reporting Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0940 in any correspondence. Do not send your completed VA Form 10-320 to this email address.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38 U.S.C. and will be used to assist us in determining your entitlement to reimbursement for services rendered. It will not be used for any other purpose. The information collected will be part of the system of records identified as 24VA19 "Patient Medical Record - VA" as set forth in the Compilation of Privacy Act Issuances via online GPO access at: http://www.gpoaccess.gov/privacyact/index.html. Disclosure is voluntary. However, failure to furnish the information will result in our inability to process your claim. Your failure to furnish this information will have no adverse effect on any other benefit to which you may be entitled.

INSTRUCTIONS: Veterans may use this form to request reimbursement for out-of-pocket emergency prescription expenses from a pharmacy that is not in VA's network and for out-of-pocket expenses for unauthorized emergency care at non-VA facilities.

In addition to meeting certain clinical and administrative requirements, to receive payment, all individuals and entities must be enrolled as a vendor with the VA. Information on how to become a vendor and where to submit this completed form is available at: http://www.va.gov/COMMUNITYCARE/programs/veterans/File-a-Claim.asp.

SECTION A: VETERAN INFORMATION

1. VETERAN'S NAME *(Last, first, middle initial)*		2. ICN# OR SSN#
3. DATE OF BIRTH *(MM/DD/YYYY)*	4. REFERRAL/AUTHORIZATION NUMBER *(If known)*	
5. VETERAN'S ADDRESS *(Include Number and Street, City, State and ZIP Code)*		

SECTION B: ITEMIZED BILL REQUIRMENTS

REIMBURSEMENT REQUESTS MUST BE SUBMITTED WITH THE FOLLOWING REQUIRED DOCUMENTS TO BE CONSIDERED FOR PAYMENT:

1. **Pharmacy reimbursement:**
   a. A valid receipt showing the amount paid for the prescription
   b. Name of the medication
   c. Medication dosage/strength
   d. Medication quantity dispensed
   e. Prescribing provider's name
   f. Date the medication was dispensed
   g. Pharmacy name and location

2. **Unauthorized Emergent Medical Care claim reimbursement:**
   a. A billing statement with a description of charges and the dates the services were provided
   b. Receipt or statement showing amount paid
   c. Description of illness/injury
   d. If applicable, primary insurance Explanation of Benefits (EOB)

Note: Medical documentation is required. If VA does not have adequate medical documentation on file, your reimbursement request may be denied for additional information.

SECTION C: SIGNED WRITTEN EXPLANATION OF WHY SERVICES WERE NOT OBTAINED THROUGH THE VA	
1. EXPLANATION	
2. SIGNATURE: I declare under penalty of perjury that the information provided in this form is true and accurate to the best of my knowledge.	3. DATE *(MM/DD/YYYY)*