



INFORMATION REGARDING POSSIBLE CLAIM AGAINST THIRD PARTY

TO	ADDRESS OF VA FACILITY District Counsel (02)	FROM	NAME AND ADDRESS OF VA FACILITY
VETERAN'S NAME <i>(Last, First, Middle Initial)</i>			TELEPHONE
VETERAN'S ADDRESS <i>(Number, Street, City, State, Zip Code)</i>			SOCIAL SECURITY NUMBER
			DATE OF THIS REPORT
NAME OF PERSON FURNISHING THIS INFORMATION, <i>if other than veteran (Last, First, Middle Initial)</i>			TELEPHONE
ADDRESS OF PERSON FURNISHING THIS INFORMATION <i>(if other than veteran)</i>			
NATURE OF-INJURY OR DISEASE			
REIMBURSABLE INSURANCE <i>(INSURANCE COMPANY + ADDRESS, POLICY NUMBER: TYPE OF COVERAGE: GROUP OR INDIVIDUAL)</i>			
IF CLAIM OR CAUSE OF ACTION IS AGAINST A THIRD PARTY; GIVE NAME AND ADDRESS OF SUCH PARTY			
<input type="checkbox"/> TORT-FEASOR <input type="checkbox"/> CRIMES OF PERSONAL VIOLENCE <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> "NO FAULT" INSURANCE			
HAS VETERAN SUBMITTED CLAIM ORALLY OR IN WRITTING <input type="checkbox"/> YES <input type="checkbox"/> NO		IF SUBMITTED TO THAN THIRD PARTY NAMED ABOVE, TO WHOM AND WHEN WAS IT SUBMITTED	
NAME, TELEPHONE NUMBER AND ADDRESSES OF WITNESSES			
GIVE DATE, TIME, EXACT LOCATION AND DESCRIPTION OF INCIDENT WHICH RESULTED IN INJURY			
WHAT AUTHORITIES, IF ANY, CONDUCTED INVESTIGATION OF INCIDENT			
HAS VETERAN CONTACTED ATTORNEY <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME AND ADDRESS OF ATTORNEY REPRESENTING VETERAN <i>(if applicable)</i>	
REMARKS			