OMB Approved No. 2900-0219
Respondent Burden: 10 Minutes
Expiration Date: 12/31/2027

Department of Veterans Affairs

CLAIM FOR MISCELLANEOUS EXPENSES

VHA Office Of Integrated Veteran Care **1-833-930-0816**

Attention: After reviewing the following information, complete the form in its entirety (print or type only) and return with the required documentation. Receipts must be provided with this form to ensure proper payment. Failure to provide the requested information will result in a delay or denial of reimbursement. If more space is needed, continue in the same format on a separate sheet.

Note: This form is required for all claims for reimbursement of miscellaneous expenses related to the treatment of spina bifida and other covered birth defects and associated covered conditions. Regardless of the type of expense being claimed, completion of Sections I, II, and IV are mandatory. Completion of Section III is required only for claims involving travel. Reimbursement for approved expenses (including attendant travel/miscellaneous expenses) will be made payable to the beneficiary.

SECTION I - PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER *(999-99-9999)*

STREET ADDRESS	DATE OF BIRTH *(MM/DD/YYYY)*

CITY	STATE	ZIP CODE *(99999-9999)*	TELEPHONE NUMBER *(Include area code) ((999) 999-9999)*

SECTION II - SPONSOR INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER *(999-99-9999)*

SECTION III - TRAVEL

Attach required receipts for expenses claimed *(receipts for privately owned vehicle mileage (POV) excluded)*

WILL THE PROVIDER BE BILLING FOR SERVICES? *(check one)* ☐ YES ☐ NO

Certification of Medical Service *(required for all travel claims)*

DATE OF SERVICE *(MM/DD/YYYY)*	PROVIDER TAX ID NUMBER	PROVIDER SIGNATURE CERTIFYING SERVICE ON SERVICE DATE *(type if electronic)*

Patient Travel Information

MODE OF TRAVEL

☐ AIRLINE ☐ TAXI ☐ POV *(round trip) (mileage)*: _____ ☐ BUS ☐ TRAIN

☐ OTHER *(Specify)*: _____

DATE OF TRAVEL *(MM/DD/YYYY)*	DEPARTURE			ARRIVAL		
	CITY	STATE	TIME *(e.g. 0815)*	CITY	STATE	TIME *(e.g. 0815)*
DATE OF TRAVEL *(MM/DD/YYYY)*	DEPARTURE			ARRIVAL		
	CITY	STATE	TIME *(e.g. 0815)*	CITY	STATE	TIME *(e.g. 0815)*

Attendant Information

LAST NAME	FIRST NAME	MI	RELATIONSHIP TO PATIENT

Patient/Attendant Miscellaneous Expenses

LODGING	OTHER *(parking, tolls, etc)*	MEALS

SECTION IV - CERTIFICATION

Federal Laws *(18 USC and 1001)* provide for criminal penalties for knowingly submitting or making any false, fictitious, or fraudulent statements or claims.

Release of Medical Information: Signature in this section authorizes the patient's providers to release medical record documentation related to the services associated with this claim. This consent pertains to all medical records, including records related to treatment for psychological and psychiatric conditions, drug and alcohol abuse, acquired immune deficiency syndrome, human immunodeficiency virus infection, and sickle cell disease.

I certify that the above information and attachments are correct and represent actual services, dates, and fees charged. (Sign and date.) If certification is signed by a person other than the patient, complete the information, signature and date.	SIGNATURE *(type if electronic)*	DATE *(MM/DD/YYYY)*

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER *(999-99-9999)*

STREET ADDRESS

CITY	STATE	ZIP CODE *(99999-9999)*	TELEPHONE NUMBER *(Include area code) ((999) 999-9999)*

PRIVACY ACT: The authority for collection of the requested information on this form is 38 U.S.C. 501 and 1805 and 38 CFR 17.900 et seq. This information is required for all claims for reimbursement of miscellaneous expenses related to the health care benefits for children of qualifying veterans. You do not have to provide the requested information but if any or all of the requested information is not provided, it may delay or result in denial of your request for payment. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled. The responses you submit are considered confidential and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records 54VA16, titled "Health Administration Center Civilian Health and Medical Program Records - VA". For example, information on this form may be disclosed to contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is voluntary. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute.

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 currently valid OMB control number. The OMB control number for this project is 2900-0219, and it expires 12/31/2027. 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 or any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at vapra@va.gov. Please refer to OMB Control No. 2900-0219 in any correspondence. Do not send your completed VA Form 10-7959e to this email address.

SPINA BIFIDA HEALTH CARE PROGRAM	**CHILDREN OF WOMEN VIETNAM VETERANS**
VHA Office of Integrated Veteran Care Spina Bifida Health Care Benefits Program P.O. Box 400 Spring City, PA 19475 **Phone:** 1-833-930-0816 **Fax:** 1-303-331-7807	VHA Office of Integrated Veteran Care Children of Women Vietnam Veterans P.O. Box 400 Spring City, PA 19475 **Phone:** 1-833-930-0816 **Fax:** 1-303-331-7807