Department of Veterans Affairs

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 *(Last, First, Middle Initial)*	TELEPHONE
VETERAN'S ADDRESS *(Number, Street, City, State, Zip Code)*	SOCIAL SECURITY NUMBER
	DATE OF THIS REPORT
NAME OF PERSON FURNISHING THIS INFORMATION, *if other than veteran (Last, First, Middle Initial)*	TELEPHONE

ADDRESS OF PERSON FURNISHING THIS INFORMATION *(if other than veteran)*

NATURE OF-INJURY OR DISEASE

REIMBURSABLE INSURANCE *(INSURANCE COMPANY + ADDRESS, POLICY NUMBER: TYPE OF COVERAGE: GROUP OR INDIVIDUAL)*

IF CLAIM OR CAUSE OF ACTION IS AGAINST A THIRD PARTY; GIVE NAME AND ADDRESS OF SUCH PARTY

☐ TORT-FEASOR
☐ WORKER'S COMPENSATION
☐ CRIMES OF PERSONAL VIOLENCE
☐ "NO FAULT" INSURANCE

HAS VETERAN SUBMITTED CLAIM ORALLY OR IN WRITTING ☐ YES ☐ 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 ☐ YES ☐ NO	NAME AND ADDRESS OF ATTORNEY REPRESENTING VETERAN *(if applicable)*

REMARKS

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054
P: 248.357.3330
F: 248.357.3337

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

FOR DISCOVERY BEFORE TRIAL

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

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

INSTRUCTIONS - Visit www.va.gov/ogc/collections.asp for the most up to date form prior to use.

1. Complete the information for VA 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 each VA Hospital that provided or paid for care.

   Select the location(s) where accident-related care was provided from the drop down lists below. Locations listed are the locations of VA Hospitals. If care was provided at a VA clinic or a non-VA provider whose exact location is not listed below, choose the location closest to where the care was provided. If more than three VA Hospitals provided or paid for care, use an additional form. Requests must be faxed or mailed to all VA Hospitals that provided or paid for care in order for VA to produce billing for all related treatment.

   Location 1: Location 2: Location 3:

   Michigan - Ann Arbor
   Fax to: 734-222-7502

If unable to Fax, the mailing address for each location selected will be displayed at the bottom of second page.

VETERAN AND INJURY DESCRIPTION

Veteran's Name (Last, First, Middle Initial)	
Veteran's Full Social Security Number	
Veteran's Mailing Address	
Veteran'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 VA Facilities Where Related Treatment Was Received	
If Related Treatment was provided at a Non-VA Facility, List all non-VA Providers	
Is Treatment Complete? If No, Describe Nature and Location of Ongoing Treatment	
Name of Veteran's Attorney	
Veteran's Attorney's Phone	
Veteran's Attorney's Mailing Address	
Veteran's Attorney's Email Address	
Veteran's Attorney's Fax	

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

Identify Applicable Insurers & Type *Examples: No Fault Insurance, Medical Payments from Veteran's Liability Insurance, Under-/Un-insured Motorist Insurance*	
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	
Only if Workers' Compensation: Name, Address, and Reference # for Workers' Compensation Board/Commission	

If unable to fax to 734-222-7502, mail to:
ATTN: CPAC
2200 Fuller Road
Ann Arbor MI 48105