TO: Department of Veterans Affairs
Post Office Box 1437
St. Petersburg, FL 33731

Identification

VA Claim Number: ____________

Veteran's Name: ____________

Beneficiary: ____________

If veteran's claim number is not available, complete the following about the veteran:
1. Veteran's SSN: ____________
2. Service Number: ____________
3. Branch of Service: ____________
4. Dates of Service: ____________
5. Date of Birth: ____________
6. Date of Death: ____________

VA Verification

List Date of Application For
1. Pension: ________ 2. Compensation: ________ 3. Aid and Attendance: ________

4. Status of claim: ☐ Pending ☐ Approved ☐ Denied

5. If the claim has been denied, please give reason: ____________

List Benefit Amounts and Effective Dates

6. Gross Pension: $________ Original Improved Effective Date: ________

Gross Compensation: $________ DIC Effective Date: ________

7. If item #1 includes an amount for a spouse/dependent, give amount and effective date.

Spouse $________ Spouse's Name ____________ Effective Date: ________

Dependent $________ Dependent's Name ____________ Effective Date: ________

8. If item #1 includes Aid and Attendance or Housebound benefits, give amount and effective date.
Aid and Attendance: $________ Housebound: ________ Effective Date: ________

9. Amount of Unreimbursed Medical Expense portion of VAIP: $________

10. Lump sum payment: $________ Date Made: ________ Spousal amount: $________

Portion which is: A&A: $________ Housebound: $________ UME: $________

Veteran, Widow or Widower's Signature: ____________ Date: ________

VA Rep's Name: ____________ Phone Number: ____________ Date: ________