VALOR
FIRM

Rating Appeal Questionnaire

Personal

Full Name: _____
Social Security Number: _____
VA Claim No.: _____
Date of Birth: _____ Place of Birth: _____

Street: _____ Phone #: (_____) _____-_____
City: _____ E-mail: _____
State and Zip: _____

VA Claim

Date(s) you filed a claim for benefits (if you filed a claim for multiple disabilities on the same date, you may list those on the same line):

Disability: _____ Date: _____
Disability: _____ Date: _____
Disability: _____ Date: _____
Disability: _____ Date: _____

Date VA denied your claim for each disability OR gave you a rating for the disability:

Date: _____ Disability: _____
◯ Denied ◯ Rating _____%
Date: _____ Disability: _____
◯ Denied ◯ Rating _____%
Date: _____ Disability: _____
◯ Denied ◯ Rating _____%
Date: _____ Disability: _____
◯ Denied ◯ Rating _____%

Date of each Compensation and Pension Exam. This is the exam arranged by the VA to assess your disability.

Date: _____ Disability: _____
Date: _____ Disability: _____
Date: _____ Disability: _____
Date: _____ Disability: _____

Have you filed a Notice of Disagreement (Form 21-0958) with VA?

◯ Yes ◯ No

If yes, when and for which disability?

Date: _____ Disability: _____
Date: _____ Disability: _____
Date: _____ Disability: _____
Date: _____ Disability: _____

Service

Active:

Branch:_____ Service No.: _____
Date(s) of service (mo/yr to mo/yr):
_____
◯ Officer ◯ Enlisted

Branch:_____ Service No.: _____
Date(s) of service (mo/yr to mo/yr):
_____
◯ Officer ◯ Enlisted

Reserve:

Branch:_____ Service No.: _____
Date(s) of service (mo/yr to mo/yr):
_____
◯ Officer ◯ Enlisted

Branch:_____ Service No.: _____
Date(s) of service (mo/yr to mo/yr):
_____
◯ Officer ◯ Enlisted

State/National Guard

Branch:_____ Service No.: _____

Date(s) of service (mo/yr to mo/yr):

_____

◯ Officer ◯ Enlisted

Branch:_____ Service No.: _____

Date(s) of service (mo/yr to mo/yr):

_____

◯ Officer ◯ Enlisted

During your State/National Guard service, were you ever placed on active duty or activated into a Title 10 status?

◯ Yes ◯ No

If yes, where and when did you serve?: _____

Do you have a copy of your DD-214?

◯ Yes ◯ No

If Yes, please include a copy of your DD-214 when you return this form.

Are you retired from military service?

◯ Yes ◯ No

Medical Treatment

Please list all hospitals and medical facilities where you received care **while in service** (this includes field hospitals, clinics, and other care received while deployed) and the approximate date of service (e.g. 03/1991 to 04/1992).

Nature of Illness, Injury or Treatment	Treatment Dates (from mo/yr to mo/yr)	Admitted overnight?	Name and Location of Facility

Please list all VA Medical Centers where you have received care, the approximate dates of service, and the disability or illness for which you were treated.

Facility:_____ Dates of care: _____
Disability/Illness:_____
Facility:_____ Dates of care: _____
Disability/Illness:_____

Facility:_____ Dates of care: _____
Disability/Illness:_____
Facility:_____ Dates of care: _____
Disability/Illness:_____

Please list all private medical facilities where you have received care related to your disability(ies) and the approximate dates of service.

Facility:_____ Dates of care: _____
Disability/Illness:_____
Facility:_____ Dates of care: _____
Disability/Illness:_____
Facility:_____ Dates of care: _____
Disability/Illness:_____
Facility:_____ Dates of care: _____
Disability/Illness:_____

Please briefly describe each disability for which you are claiming benefits:

_____
_____
_____
_____
_____
_____

Please use this space for additional responses or any other information you feel is relevant to your claim:

_____
_____
_____
_____
_____
_____