VA Medical Care Copayment

* Required Entry

Veteran Information

Please have a copy of the Veteran Patient Statement sent from Department of Veterans Affairs in front of you to enter the correct information.

* Veteran's First Name: __________________________

Middle Initial: __

* Veteran's Last Name: __________________________

* Account Number: ______________________________

Payer Information

The following questions must reflect the identity of the person making the payment.

* Payer's Name: ________________________________

* Payer's Telephone Number: ____________________

Payer's Email Address: (if available) __________________

Payment Information

* Payment Amount: $ ____________________________

This form should only be used to pay VA health care copayments and/or VA prescription copayments. Please verify Veteran name and account number match information on the Veteran Patient Statement before submitting your payment. Incorrect information or wrong form used will delay payment posting.

If you do not have a statement or need assistance with this form, please call 888-827-4817 Monday-Friday, between 8am-8pm(EST).

Note: If clicking continue does not move to the payment page, please click your browser's refresh button, complete the form, and click continue.