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: [Input field]

Middle Initial: [Input field]

* Veteran's Last Name: [Input field]

* Account Number: [Input field]

**Payer Information**

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

* Payer's Name: [Input field]

* Payer's Telephone Number: [Input field]

Payer's Email Address: (if available) [Input field]

**Payment Information**

* Payment Amount: $ [Input field]

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.