



# U.S. Department of Veterans Affairs

## 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:

[Where do I find my VA 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.