

## Department of Veterans Affairs

## § 17.1000

(d) *Explanation of benefits (EOB)*—(1) When a claim under the provisions of §§ 17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides, at a minimum, the following information:

- (i) Name and address of recipient,
- (ii) Description of services and/or supplies provided,
- (iii) Dates of services or supplies provided,
- (iv) Amount billed,
- (v) Determined allowable amount,
- (vi) To whom payment, if any, was made, and
- (vii) Reasons for denial (if applicable).

(2) [Reserved]

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0578)

### § 17.904 Review and appeal process.

For purposes of §§ 17.900 through 17.905, if a health care provider, child, or representative disagrees with a determination concerning provision of health care or with a determination concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing (by facsimile, mail, or hand delivery) within one year of the date of the initial determination to the Health Administration Center (Attention: Chief, Benefit and Provider Services). The request must state why it is believed that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the sender without further consideration. After reviewing the matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses, or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may submit in writing (by fac-

simile, mail, or hand delivery) to the Health Administration Center (Attention: Director) a request for review by the Director, Health Administration Center. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses, or modifies the previous decision. An appeal under this section would be considered as filed at the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

NOTE TO § 17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0578)

### § 17.905 Medical records.

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment or that VA determines are necessary to adjudicate claims under §§ 17.900 through 17.905 must be provided to VA at no cost.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

### PAYMENT OR REIMBURSEMENT FOR EMERGENCY SERVICES FOR NON-SERVICE-CONNECTED CONDITIONS IN NON-VA FACILITIES

SOURCE: 66 FR 36470, July 12, 2001, unless otherwise noted.

### § 17.1000 Payment or reimbursement for emergency services for non-service-connected conditions in non-VA facilities.

Sections 17.1000 through 17.1008 constitute the requirements under 38 U.S.C. 1725 that govern VA payment or reimbursement for non-VA emergency services furnished to a veteran for non-service-connected conditions.

(Authority: 38 U.S.C. 1725)