OMB Control No. 2900-0886
Respondent Burden: 15 minutes
Expiration Date: 05/31/2027

VA U.S. Department of Veterans Affairs

DECISION REVIEW REQUEST: SUPPLEMENTAL CLAIM

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden information on page 3 before completing the form. Use this form to submit a claim if you disagree with a decision you received. For more information you can contact us online through Ask VA: https://ask.va.gov/ or call us toll-free at 1-800-698-2411 (TTY:711). If you prefer you may complete and submit the form online by using the addresses and weblinks listed in the Instructions, Page 1 or 2.

1. BENEFIT TYPE (**PLEASE CHECK ONLY ONE BOX**)
Note: If you would like to file for multiple benefit types, you must complete a separate VA Form 20-0995 for each benefit type.

- [X] COMPENSATION
- [ ] PENSION/DIC/SURVIVORS BENEFITS
- [ ] FIDUCIARY
- [ ] EDUCATION
- [ ] LOAN GUARANTY
- [ ] LIFE INSURANCE
- [ ] VETERAN READINESS AND EMPLOYMENT
- [ ] NATIONAL CEMETERY ADMINISTRATION
- [ ] VETERANS HEALTH ADMINISTRATION (**NOTE**: If checked, specify in the space provided below, which benefit type you are claiming for VHA. (e.g., Travel/Mileage Reimbursement, Medical Treatment Reimbursement, Health Care Eligibility, Clothing Allowance, etc.)

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable checkbox to help expedite processing of the form.

2. VETERAN'S NAME (First, Middle Initial, Last)
John A Doe

3. SOCIAL SECURITY NUMBER
111-11-1111

4. VA FILE NUMBER (If applicable)
111111111

5. DATE OF BIRTH (MM/DD/YYYY)
01-01-1970

6. SERVICE NUMBER (If applicable)
111111111

7. VA INSURANCE POLICY NUMBER (If applicable)

8. MAILING ADDRESS (Number, street or rural route, P.O. Box, City, State, ZIP Code and Country)
No. & Street: 123 Veteran Rd
Apt./Unit Number:
City: Houston
State/Province: TX
Country: US
ZIP Code/Postal Code: 12345 –

9. TELEPHONE NUMBER (Optional) (Include Area Code)
123-456-7890
Enter International Phone Number (If applicable)

10. E-MAIL ADDRESS (Optional)

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY IF the claimant is NOT the veteran)

11. CLAIMANT'S NAME (First, Middle Initial, Last) (If **other** than veteran)

12. SOCIAL SECURITY NUMBER

13. VA FILE NUMBER (If applicable)

14. DATE OF BIRTH (MM/DD/YYYY)

15. VA INSURANCE POLICY NUMBER (If applicable)

16. RELATIONSHIP TO VETERAN (Check one)
- [ ] SPOUSE
- [ ] CHILD
- [ ] FIDUCIARY
- [ ] PARENT
- [ ] OTHER (Specify)

17. MAILING ADDRESS (Number, street or rural route, P.O. Box, City, State, ZIP Code and Country)
No. & Street:
Apt./Unit Number:
City:
State/Province:
Country:
ZIP Code/Postal Code: –

18. TELEPHONE NUMBER (Optional) (Include Area Code)
Enter International Phone Number (If applicable)

19. E-MAIL ADDRESS (Optional)

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 20A through 20D) should **ONLY** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

20A. ARE YOU CURRENTLY HOMELESS OR AT RISK OF BECOMING HOMELESS?

☐ YES (If "Yes," complete Items 20B through 20D regarding your living situation)

☐ NO (If "No," skip to Item 21)

20B. WHICH OF THESE STATEMENTS BEST DESCRIBES YOUR LIVING SITUATION? (Select all that apply)

☐ I LIVE OR SLEEP IN A PLACE THAT IS NOT MEANT FOR REGULAR SLEEPING (e.g., a car, park, abandoned building, bus station, train station, airport or camp ground)

☐ I LIVE IN A SHELTER (e.g., a hotel or motel that is meant for temporary stays)

☐ I AM STAYING WITH A FRIEND OR FAMILY MEMBER, BECAUSE I AM UNABLE TO OWN A HOME RIGHT NOW

☐ IN THE NEXT 30 DAYS, I WILL HAVE TO LEAVE A FACILITY, LIKE A HOMELESS SHELTER

☐ IN THE NEXT 30 DAYS, I WILL LOSE MY HOME
Note: This selection includes any house, apartment, trailer, or other living space that you own, rent, or live in without paying rent, any hotels or motels that are meant for temporary stays, or a living space that you share with others.)

☐ NONE OF THESE SITUATIONS APPLY TO ME

Note: We understand that you may have other housing risks not listed here. If you feel comfortable sharing more about your situation, you can check `other' and specify in the space provided. Or you can check `other' and not include any details. We will use this information only to prioritize your request.

☐ OTHER (Specify)

20C. POINT OF CONTACT (Name of person VA can contact in order to get in touch with you)

20D. POINT OF CONTACT TELEPHONE NUMBER (Include Area Code)

– –

Enter International Phone Number (If applicable)

SECTION IV: ISSUE(S) FOR SUPPLEMENTAL CLAIM

21. YOU MUST LIST EACH ISSUE DECIDED BY VA THAT YOU WOULD LIKE VA TO REVIEW AS PART OF YOUR **SUPPLEMENTAL CLAIM** (**Note**: Refer to your decision notice(s) for a list of adjudicated issues. For each issue, identify the date of VA's decision.)

If you are responding to a Statement of the Case (SOC) or a Supplemental Statement of the Case (SSOC): By submitting this form, I agree to participate in the modernized review system for the following issues decided in a SOC or SSOC. I am withdrawing the eligible appeal issues listed in Item 21A in their entirety, and any associated hearing requests, from the legacy appeals system. I understand I cannot return to the legacy appeals system for the issue(s) withdrawn.

21A. SPECIFIC ISSUE(S)	21B. DATE OF VA DECISION NOTICE
Knee Pain and Back Pain	01 – 01 – 2025
	– –
	– –
	– –
	– –
	– –
	– –
	– –
	– –

SECTION V: NEW AND RELEVANT EVIDENCE

IMPORTANT: To complete your application, you must submit new and relevant evidence to VA or tell us about new and relevant evidence that VA can assist you in gathering in support of your **supplemental claim**. If you have records in your possession, attach the records to this form. List your name and file number on each page. If you would like VA to obtain non-Federal records, review your decision notification letter or read the instructions for this section on Page 3 that lists the appropriate forms to complete and submit those forms to VA with this request form. **Note**: Unless your **supplemental claim** is based on a change in law, you'll need to submit supporting evidence that's **new and relevant** for your application to be complete. You can also identify evidence you'd like us to gather for you.

22A. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that apply)

- [X] PRIVATE HEALTH CARE PROVIDER (including non-Federal records)
- [ ] VA VET CENTER
- [ ] COMMUNITY CARE (Paid for by VA)
- [X] VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)
- [X] DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)
- [ ] OTHER (Specify):

Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your **private provider, (excluding community care (paid for by VA)) or VA Vet Center health records**, VA requires your consent by completing VA Forms 21-4142, *Authorization to Disclose Information to VA,* and 21-4142a, *General Release for Medical Provider Information to VA*. VA forms are available at **www.va.gov/vaforms**.

Note: If treatment began from 2005 to present, you ***do not*** need to provide in Item 22C the date(s) of treatment.

22B. NAME AND LOCATION OF THE TREATMENT FACILITY	22C. DATE(S) OF TREATMENT (Approximate dates are acceptable) (MM-YYYY)	22D. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
DOD MTF, Ft. Bragg, North Carolina	05 – 2015	☐ Don't have date
Houston Medical Group, Houston, TX	12 – 2024	☐ Don't have date
Houston VA, Houston, TX	01 – 2025	☐ Don't have date

SECTION VI: 5103 NOTICE OF ACKNOWLEDGMENT
(This section applies to Compensation, Pension, DIC, and Accrued benefit claims only.
Note: If we issued your decision within the past year, skip to Section VII

23. FOR SPECIFIC EVIDENCE YOU NEED TO PROVIDE WITH YOUR CLAIM, VISIT ONE OF THESE PAGES ON www.va.gov.

- Evidence to support a claim for Veterans Disability Compensation and related Compensation benefits: https://www.va.gov/disability/how-to-file-claim/evidence-needed/.
- Evidence to support a claim for VA pension, DIC, or accrued benefits: https://www.va.gov/resources/evidence-to-support-va-pension-dic-or-accrued-benefits-claims/.

I CERTIFY THAT I HAVE REVIEWED THE NOTICE OF EVIDENCE THAT RELATES TO MY CLAIM.

- [X] YES
- [ ] NO (If you check "No," VA will send the 5103 notice to you via mail.)

SECTION VII: OPTION FOR VETERANS BENEFITS ADMINISTRATION (VBA) TO NOTIFY VETERANS HEALTH ADMINISTRATION (VHA) ABOUT CERTAIN UPCOMING EVENT(S) DURING THE CLAIM AND OR APPEAL PROCESS

IMPORTANT: For information on VHA health care services, visit **www.va.gov/health-care/about-va-health-benefits**. To learn more about VHA health care services available related to military sexual trauma (MST), you can contact a VHA MST Coordinator. A list is available at **www.mentalhealth.va.gov/msthome/vha-mst-coordinators.asp** or you can contact your local VA medical facility and ask to speak to the MST Coordinator.

24. If you are filing a claim for compensation for a condition due to a personal traumatic event(s**)** involving MST and you are registered and/or enrolled for VHA health care, you have the option for VBA to electronically notify VHA about certain upcoming event(s) during your claim and/or appeal process. These event(s) are any scheduled compensation and pension (C&P) examination, hearing before the Board of Veterans' Appeals, and any decision notification. When notified, VHA will place an indicator in your medical record to alert VA health care providers that these event(s) are scheduled to occur. Notifications to VHA would only indicate the type of event(s) and potential time frame, not any details specific to your claim. The indicator in your medical record would not identify your claim as MST-related, but at this time, only claimants filing MST-related claims are provided this notification option. For this reason, providers may know that the indicator is in relation to an MST-related claim. The decision to **consent, not consent, or revoke prior consent** into the automatic notification system will not affect the status or outcome of your claim. **A response is not required**. If you do not respond, VBA will not send electronic notifications to VHA, nor will the outcome of your claim be impacted. If you would like VBA to send these electronic notifications to VHA, please indicate your consent by selecting a check box below.

- [ ] A. **I CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these event(s) will appear in my VHA medical record.)
- [ ] B. **I DO NOT CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these event(s) will not appear in my VHA medical record.)
- [ ] C. **I REVOKE PRIOR CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENT(S) RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that in the future, notice of these event(s) will no longer appear in my VHA medical record.)
- [X] D. **NOT APPLICABLE AND/OR NOT ENROLLED OR REGISTERED IN VHA HEALTH CARE**

Note: You have the option to modify your previous selection at any time. Mail your correspondence to: **Department of Veterans Affairs, Compensation Intake Center, P.O. Box 4444, Janesville, WI 53547-4444**.

SECTION VIII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

25A.VETERAN/CLAIMANT'S SIGNATURE	25B. DATE SIGNED (MM/DD/YYYY)
John A. Doe	03 – 03 – 2025

SECTION IX: WITNESSES TO SIGNATURE
(Note: Only use this section if the veteran/claimant used an "X" in Item 25A)

26A. SIGNATURE OF THE FIRST WITNESS	26B. PRINTED NAME AND ADDRESS OF FIRST WITNESS Name: Address:
27A. SIGNATURE OF THE SECOND WITNESS	27B. PRINTED NAME AND ADDRESS OF SECOND WITNESS Name: Address:

SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (Note: Required only if Item 25A is blank.)

NOTE 1: An alternate signer signature **will not** be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

NOTE 2: For insurance appeals, either VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, VA Form 21-22A, *Appointment of Individual as Claimant's Representative*, **OR** VA Form 21P-555, *Certificate of Legal Capacity to Receive and Disburse Benefits and Fee Authorization,* needs to be of record to allow an alternate signer to sign on behalf of the claimant.

I CERTIFY THAT by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

28A. ALTERNATE SIGNER'S SIGNATURE	28B. DATE SIGNED (MM/DD/YYYY) – –

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE
(Note: This section does not apply to insurance claims)

I CERTIFY THAT the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

NOTE: A POA's signature ***will not*** be accepted unless at the time of submission of this claim a valid VA Form 21-22, or VA Form 21-22a, indicating the appropriate POA is of record with VA.

29A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE	29B. DATE SIGNED (MM/DD/YYYY) – –
29C. ACCREDITATION NUMBER	29D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED (If known) – –

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES | THIS IS AN IMPORTANT RECORD. SAFEGUARD IT. | ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF UNIFORMED SERVICE

When completed, this form contains personally identifiable information and is protected in accordance with the Privacy Act of 1974, as amended, and DoD 5400.11-R, DoD Privacy Program.

1. NAME (Last, First, Middle)	2. BRANCH AND COMPONENT	3. DOD ID NUMBER	4. SERIAL NUMBER:
Doe, John A	ARMY	111111111	111111111

5a. GRADE, RATE OR RANK	b. PAY GRADE	6. DATE OF BIRTH (YYYYMMDD)
E-7	E-7	19700101

7a. MILITARY SERVICE OBLIGATION TERMINATION DATE (YYYYMMDD)	b. RESERVE STATUS FOR OBLIGATION (SELRES/IRR)	c. CONTACT PHONE NUMBER (Civilian)	d. CONTACT EMAIL ADDRESS (Civilian)
20150101		(123)456-7890	johndoe@gmail.com

8a. PLACE OF ENTRY INTO ACTIVE DUTY	b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)
HOUSTON, TX	123 Veteran Rd., Houston, TX 12345

9a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	b. STATION WHERE SEPARATED
18th Airborne Corps	Ft. Knox, KY 458521

10. COMMAND TO WHICH TRANSFERRED	11. SGLI COVERAGE / AMOUNT: $
88th Ready Reserve, Ft. McCoy, WI 45787	☐ NONE

12. SPECIALITY *(List number, title, and years and months in specialties involving periods of one or more years.)*

11B INFANTRYMAN - 15 YRS 0 MOS//NOTHING FOLLOWS

13. RECORD OF SERVICE	YEAR(S)	MONTH(S)	DAY(S)
a. DATE ENTERED AD THIS PERIOD	1992	10	01
b. SEPARATION DATE THIS PERIOD	2015	09	03
c. NET ACTIVE SERVICE THIS PERIOD	0023	00	00
d. TOTAL PRIOR ACTIVE SERVICE	0000	00	00
e. TOTAL ACTIVE SERVICE	0023	00	00
f. TOTAL INACTIVE SERVICE	0000	00	00
g. FOREIGN SERVICE	0001	00	00
h. SEA SERVICE	0000	00	00
i. INITIAL ENTRY TRAINING			
j. EFFECTIVE DATE OF PAY GRADE	2010	01	01

14. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED *(All periods of service)*

BRONZE STAR MEDAL//ARMY COMMENDATION MEDAL (2ND AWARD)//ARMY ACHIEVEMENT MEDAL (2ND AWARD)//NATIONAL DEFENSE SERVICE MEDAL (2ND AWARD)//ARMED FORCES EXPEDITIONARY MEDAL//GLOBAL WAR ON TERRORISM EXPEDITIONARY//CONT IN BLOCK 18

15. UNIFORMED SERVICE EDUCATION *(Course title, number of weeks, and month and year completed)*

16. DAYS ACCRUED LEAVE PAID	17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION
	☒ YES ☐ NO

18. RETIREMENT SYSTEM OPTION					19. DD214-1 (Accompanies this DD214)	
☐ FINAL	☐ HIGH-3	☒ REDUX	☐ BRS		☒ YES	☐ NO

20. REMARKS

SERVED IN A DESIGNATED IMMINENT DANGER PAY AREA/ SERVICE IN IRAQ 20100101-20110101//
INDIVIDUAL COMPLETED PERIOD FOR WHICH ORDERED TO ACTIVE DUTY FOR PURPOSE OF POST SERVICE BENEFITS AND ENTITLEMENTS//ORDERED TO ACTIVE DUTY IN SUPPORT OF OPERATION IRAQI FREEDOM IAW 10 USC 12302//MEMBER HAS COMPLETED FIRST FULL TERM OF SERVICE//CONT FROM BLOCK 13: MEDAL//
GLOBAL WAR ON TERRORISM SERVICE MEDAL//ARMED FORCES SERVICE MEDAL (AFSM)//IRAQ CAMPAIGN MEDAL W/ CAMPAIGN STAR//ARMY SERVICE RIBBON//OVERSEAS SERVICE RIBBON (2ND AWARD)//ARMED FORCES

The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or non-Federal agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal benefit program.

21a. MAILING ADDRESS AFTER SEPARATION (Include ZIP Code)	21b. NEAREST RELATIVE (Name and address - include ZIP code)
123 Veteran Rd., Houston, TX 12345	Mary Doe 123 Veteran Rd., Houston, Tx 12345

22. MEMBER REQUESTS DATA SHARE WITH *(Specify state/locality)* **OFFICE OF VETERANS AFFAIRS** ☒ YES ☐ NO

23a. MEMBER SIGNATURE	b. DATE (YYYYMMDD)	24. OFFICIAL AUTHORIZED TO SIGN	
		a. NAME, GRADE AND TITLE	c. DATE (YYYYMMDD)
		b. SIGNATURE	

REBUTTAL

March 11, 2025

John A. Doe
123 Veteran Rd.
Houston, TX 12345

TO: Department of Veterans Affairs

SUBJECT: Supplemental Claim for Review – Knee and Back Pain Due to New and Relevant Evidence

Background

I, **John A. Doe**, am submitting this **supplemental claim for review** based on **new and relevant medical evidence** that supports my VA disability claim for **knee and back pain**. Since my initial claim decision, I have obtained **additional medical documentation** that further proves the **severity and progression** of my condition.

Disability Information

- **Primary Disability:** Knee Pain
- **Secondary Disability:** Back Pain

Symptoms and Diagnosis

I first began experiencing **left knee pain, right knee pain, and pain in both knees** while stationed at **Ft. Bragg, North Carolina** during active duty. My condition was diagnosed in **July 2013**, and treatment has continued since then.

Treatment History

- **May 2015:** Initial diagnosis and treatment
- **December 2024:** Continued treatment for knee and back pain
- **January 2025:** Further evaluation and medical management

New and Relevant Evidence

Since my last claim submission, I have obtained **new medical evidence that was not previously considered**, including:

1. **Medical Records of Weekly Chiropractor Visits** – I have been undergoing **regular chiropractic care** to manage **chronic pain, joint misalignment, and stiffness** related to my knee and back conditions. These records demonstrate the **ongoing and worsening nature of my condition**.
2. **MRI Results Showing Deterioration in Knee and Hip Joints** – Recent imaging **confirms progressive joint degeneration**, which **substantiates the severity and long-term impact of my service-connected injuries**. These findings support my claim that my condition has worsened beyond what was previously documented.

Current Treatment and Medications

I continue receiving treatment at **Houston VA, Houston, TX**, which includes:

- **Prescription Medications:**
  - **Naproxen and Advil** – For pain and inflammation management
  - **RINVOQ** – Recently prescribed to treat **active psoriatic arthritis (PsA)**, which further impacts my knee function
- **Physical Therapy:** Regular therapy sessions to maintain **joint mobility and reduce stiffness**
- **Knee Brace Usage:** To provide stability and support

Impact of New Medication and Worsening Condition

The introduction of **RINVOQ** has introduced **severe side effects**, including:

- **Nausea and vomiting**
- **Severe headaches**
- **Further reduction in my quality of life**

In addition to my **progressive knee and back pain**, the **side effects of this new medication have made it even more difficult to perform daily activities**. Tasks such as **walking, standing for extended periods, and engaging in normal routines** have become increasingly challenging.

Request for Claim Review

Given the **new MRI evidence and weekly chiropractor treatment records**, along with the **worsening of my symptoms and introduction of additional treatments with severe side effects**, I respectfully **request a full review of my VA claim**. The **newly available medical records and diagnostic imaging** provide **objective proof of my condition's severity** and confirm its **ongoing impact on my quality of life**.

Conclusion

With this **new and relevant medical evidence**, I urge the **VA to reconsider my disability claim** and acknowledge the **progression and continued impact of my knee and back conditions**. If any additional information is required, I am available to provide further documentation.

Sincerely,

John A. Doe

John A. Doe

NEXUS SUPPORT STATEMENT

[Physician's Letterhead]
Houston VA
124 Bronson Street
Houston, TX 12345
Phone: (718) 242-5254

March 11, 2025

TO: Department of Veterans Affairs

RE: Medical Nexus Statement for Supplemental Claim – John A. Doe
123 Veteran Rd.
Houston, TX 12345

SUBJECT: Nexus Letter in Support of VA Disability Claim for Knee and Back Pain – New and Relevant Evidence

To Whom It May Concern,

I am **Dr. William Stryker, MD, Orthopedic Specialist**, currently practicing at **Houston VA**, and I am writing this letter in support of **John A. Doe's** supplemental VA disability claim for **knee pain and secondary back pain**. Based on new and relevant medical evidence, I believe that Mr. Doe's condition has worsened beyond what was previously documented, and his symptoms continue to have a profound impact on his quality of life.

Medical History and Diagnosis

Mr. Doe has been under my medical care for **chronic knee pain and secondary back pain** since **May 2015**, following his **military service and initial onset of symptoms at Ft. Bragg, North Carolina**. His symptoms include:

- **Left knee pain, right knee pain, and pain in both knees**
- **Back pain**
- **Nausea, vomiting, and severe headaches** (related to recent treatment)

His **treatment history includes:**

- **May 2015:** Initial diagnosis and treatment
- **December 2024:** Follow-up treatment
- **January 2025:** Continued evaluation and pain management

New and Relevant Evidence

Since Mr. Doe's initial claim submission, **new medical evidence has become available** that further confirms the **severity and progression of his condition**:

1. **Medical Records of Weekly Chiropractor Visits** – Demonstrating **persistent and worsening pain** requiring continuous treatment to manage symptoms.
2. **Recent MRI Showing Joint Deterioration** – Confirming **progressive degeneration of the knee and hip joints**, which was **not previously documented** in earlier medical evaluations. This **objective imaging evidence** substantiates his **worsening condition** and supports a claim for an increased disability rating.

Current Treatment and Medications

Mr. Doe continues treatment at **Houston VA, Houston, TX**, which includes:

- **Pain management medications:**
  - **Naproxen and Advil** for inflammation and pain relief
  - **RINVOQ**, prescribed for **active psoriatic arthritis (PsA)**, which further affects joint function
- **Regular Physical Therapy Sessions** to maintain mobility and prevent further deterioration
- **Use of a Knee Brace** for stability and joint support

Impact of New Treatment and Condition Progression

The introduction of **RINVOQ** has led to **adverse side effects**, including:

- **Nausea and vomiting**
- **Severe headaches**
- **Further deterioration in overall well-being**

These side effects, combined with his **worsening knee and back pain**, have **significantly reduced his quality of life**. Mr. Doe struggles with **daily tasks, mobility, and physical activity**, further exacerbating his **physical and emotional distress**.

Request for Claim Review

Given the **new and objective medical evidence, including MRI findings and ongoing chiropractic treatments**, and the **worsening symptoms due to prescribed medications**, I strongly recommend that **Mr. Doe's disability claim be reevaluated** for an **increased rating and service connection consideration**. His condition continues to deteriorate and now includes **additional medical complications that were not previously accounted for in his initial claim**.

Conclusion

Based on my **medical expertise, evaluation of Mr. Doe's service history, and newly obtained medical evidence**, I conclude that:

1. **His knee and back pain conditions have worsened beyond their previously documented severity.**

2. **Recent MRI and chiropractic records provide objective proof of ongoing joint deterioration.**
3. **The new medication RINVOQ has introduced additional disabling symptoms, including nausea, vomiting, and severe headaches, further diminishing his quality of life.**

I respectfully request that the **VA review this supplemental claim and consider the new medical evidence provided** in support of Mr. Doe's **ongoing and worsening disability**. If any further clarification is needed, I am available to provide additional documentation.

Sincerely,

William Stryker

William Stryker, MD
Orthopedic Specialist
Houston VA

ADD MEDICAL DOCUMENTS HERE