Subject: **Treatment of Combat-Related Disability – Provider Confirmation**

From: Patient Name: _____

Patient Home Address: _____

Patient City / State: _____

Patient Phone and/or e-mail

To: Provider Name: _____

My branch of the military has determined that I have one or more combat-related disabilities as listed in the attached letter regarding Combat-Related Special Compensation. I may be eligible for travel reimbursement for necessary specialty care associated with my combat-related disability. To be reimbursed for my travel expenses, I must provide documentation from you about the care I receive today.

Please verify below that, in your opinion, the care I am receiving today is to treat a combat-related disability listed on the letter (mention disabilities treated below).

Thank you

Treatment Information Treatment Date: _____

_____

Specialty Care Provider Signature Date

Provider Office/ Treating Facility Information

Name: _____

Office Address: _____

City / State / Zip: _____

Phone and/or e-mail: _____