Veterans Health Administration

Tribal Health

"Connecting Health Care & Culture...Through Partnership, Respect & Understanding"





Apply for the American Indian/Alaska Native Veteran Copayment Exemption

What is the copay exemption?

The law stating American Indian/Alaska Native Veterans do not pay copays for VA health care services and urgent care visits.

Who can receive the copay exemption?

American Indian/Alaska Native Veterans who are enrolled in VA health care. Access the QR code on the right for more information.

How do I apply for the copay exemption?

Complete the following three steps:

1. Make a **copy** of only **one** of the following Official Tribal Documents, including, but not limited to:
   - Tribal Enrollment or Citizenship/Membership ID Card, or
   - Certificate of Degree of Indian or Alaska Native Blood issued by the Bureau of Indian Affairs, or
   - Documentation issued by a Tribe on official letterhead indicating individual affiliation.
2. Fill out VA Form 10-334 and make a **copy**. The form can be found at https://www.va.gov/find-forms/about-form-10-334.
3. Mail both documents to the address below:

VHA Tribal Documentation
PO Box 5100
Janesville, WI 53547-5100

Note: *Copies can be made at your local VA medical center or clinic; printed copies of VA Form 10-334 are also available. Learn more about the copayment exemption here: https://www.va.gov/resources/copay-exemptions-for-american-indian-and-alaska-native-veterans/*

VA | U.S. Department of Veterans Affairs

Veterans Crisis Line
Dial 988 and Press 1
or text to 838255.

OMB Control Number: 2900-0920
Estimated Burden: 15 minutes
Expiration Date: 04/30/2026

Department of Veterans Affairs

TRIBAL DOCUMENTATION FORM

Personally Identifiable Information (PII) Form

VA DATE STAMP
(For VHA Use Only)

PAPERWORK REDUCTION ACT STATEMENT: This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, VA may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this form will average 15 minutes. This includes the time it will take to follow instructions, gather the necessary facts, and respond to questions asked. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled.

PRIVACT ACT STATEMENT: The information requested on this form is solicited pursuant to section 3002 of the Veterans Health Care and Benefits Improvement Act(Public Law 116-315). The purpose of this data collection is to provide your contact information and a copy of tribal documentation in support of your claim for an exemption from co-payments for certain hospital care and medical services. Your disclosure of the information requested on this form is voluntary. However, if information needed is not furnished completely and accurately, VA may be delayed or unable to comply with the request. VA may make a "routine use" disclosure of information provided on this form as permitted by the Privacy Act when the information will be used for a purpose that is compatible with the purpose for which VA collected the information.

IMPORTANT: In accordance with section 3002 of the Veterans Health Care and Benefits Improvement Act, Public Law 116-315, all co-payments for hospital care and medical services received on or after January 5, 2022 are exempted for American Indian and Alaska Native Veterans eligible for VA health care. In order to be eligible for these co-payment exemptions, this form, along with a copy of tribal documentation, must be completed and provided to VA (as further explained below).

INSTRUCTIONS: Please fill out the below information in Section I. **Submit this form, along with a COPY of the requested Tribal Documentation. Any items provided will not be returned.** Any field with a (*) is required for submission. To submit the form and supporting documentation, please utilize the mailing address below:

Please mail documents to:
VHA Tribal Documentation
PO Box 5100
Janesville, WI 53547-5100

SECTION I: VETERAN IDENTIFICATION INFORMATION

(Note: Completion of this section is REQUIRED to process your request; any omission may delay processing.)

Federal law provides criminal penalties, including a fine and/or imprisonment, for any materially false, fictitious, or fraudulent statement or representation. (See 18 U.S.C. 287 and 1001).

1. VETERANS NAME *(Last, First, Middle)**		2. DATE OF BIRTH *(MM/DD/YYYY)**
3A. CURRENT MAILING ADDRESS		3B. CITY
3C. STATE	3D. ZIP CODE	3E. COUNTY
4. VA MEMBER ID Number **OR** SOCIAL SECURITY NUMBER*	5. EMAIL ADDRESS	6. LOCAL VA MEDICAL CENTER See List of VA Facilities. *(If known)*

7. VETERAN TELEPHONE NUMBER *(Please select the best time of day to call)*

☐ MORNING ☐ AFTERNOON ☐ EVENING

8. SIGNATURE*	9. DATE *(MM/DD/YYYY)**

If you have any questions or need more information, please visit www.va.gov/health-care/copay-rates.