



This form should be used by claimants to clarify a discrepancy in the information submitted with a claim **or** to identify the appropriate claim to move forward for review. **If the VCF contacted you about a discrepancy with your claim, we cannot continue with the processing of your claim until you complete and return this form.** You may mail, fax, or upload this form to your claim. If you need assistance completing this form, please call our toll-free Helpline at 1-855-885-1555.

Note: If you upload the completed form to your claim, select the **“Claim Information Resolution Form”** document type.

Victim/Claimant Information (required)

VCF Claim Number: _____

Victim/Claimant Full Legal Name

First Name *Middle Name* *Last Name*

Victim Social Security Number: _____

Date of Birth (mm/dd/yyyy): _____

Personal Representative Information (required only if victim is deceased)

Personal Representative Full Legal Name

First Name *Middle Name* *Last Name*

Social Security Number: _____

Date of Birth (mm/dd/yyyy): _____

Selection of Claim for VCF Review (if applicable)

If you initiated or submitted more than one registration or claim, the VCF cannot begin processing your claim until you identify a single claim to pursue and withdraw any other claims filed on the victim’s behalf. Complete the information below to select the claim the VCF should review.

I request that the VCF move forward with claim number:

VCF _____

I understand that all other claims associated with the victim’s Social Security Number will be cancelled and withdrawn.

Signature (required) – *By signing below, I authorize the VCF to make the necessary updates to my claim.*

Victim/Claimant Signature

Date