

**REQUEST FOR RE-REVIEW
OF
DISEASE COMPENSATION CLAIM**

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Social Security Number	Date of Birth
_____	_____
Last Name	First Name
To assure proper recording and filing, print legibly. Use correct Social Security number.	

Attached is the documentation necessary to cure the deficiencies originally noted in my disease compensation claim.

Please re-review my claim as soon as possible.

Date Signed

Signature of Claimant or her Attorney

MDL-926 Claims Office
PO Box 56666
Houston, Texas 77256