



COMMUNITY CARE PROVIDER - REQUEST FOR SERVICE
(Seperate Form for Each Service Requested)

Note: Requests are approved/denied at VA Medical Center's discretion. *Means the field is required

VA FACILITY INFORMATION: (Facility Name) *TODAY'S DATE (mm/dd/yyyy) FAX NUMBER PHONE NUMBER

INITIAL AUTHORIZATION

*UNIQUE IDENTIFIER: VA AUTHORIZATION/REFERRAL NUMBER *REQUEST PRIORITY
WITHIN 1 WEEK WITHIN 1 MONTH WITHIN 48 HOURS*
OTHER (Please Specify):
*Note: if care is needed within 48 hours, please contact your VAMC directly

VETERAN INFORMATION

*VETERAN'S NAME (Last, First, MI) *SSN (last four digits) *DATE OF BIRTH (mm/dd/yyyy)

REQUESTING PROVIDER INFORMATION

*INDIVIDUAL OR GROUP PRACTICE NAME *REQUESTING PROVIDER NAME *PROVIDER 24-HR EMERGENCY CONTACT NUMBER (for abnormal/critical findings)
*INDIVIDUAL OR GROUP PRACTICE NPI (REQUIRED) *PROVIDER EMAIL ADDRESS *PROVIDER DAYTIME CONTACT NUMBER
*SPECIALTY TYPE *FACILITY ADDRESS *PROVIDER FAX NUMBER

REQUESTED SERVICE - ONE SERVICE PER FORM

SUPPORTING DOCUMENTATION MUST ACCOMPANY THIS REQUEST

*SERVICE REQUESTED (One Per Form)
ACUTE REHAB SURGICAL PROCEDURE
IN-OFFICE PROCEDURE INPATIENT
INPATIENT CARE OUTPATIENT
OFFICE VISIT DURABLE MEDICAL EQUIPMENT (DME)
TYPE OF REQUEST
ADDITIONAL TIME
ADDITIONAL VISITS (DME Education/Training)
OTHER

NOTE: For requests that are not listed on this form, please contact your VAMC directly (e.g. transplant, long term care, Homemaker and Home Health Aid (H/HHA))

SPECIALITY

MEDICAL
ALLERGY AND IMMUNOLOGY MENTAL HEALTH
CARDIOLOGY GENERAL MATERNITY/OBSETRICS
CARDIOLOGY TESTING NEPHROLOGY
DEMENTIA NEUROLOGY
ENDOCRINOLOGY PRIMARY CARE
GERIATRIC ASSESSMENT PAIN MANAGEMENT
GASTROENTEROLOGY PULMONARY
GYNECOLOGY RADIATION ONCOLOGY
HEMATOLOGY/ONCOLOGY RHEUMATOLOGY
HYPERTENSION SLEEP STUDY/POLYSOMNOGRAPHY
INFECTIOUS DISEASE TRANSPLANT/REFERRAL CONSULT
INFUSION THERAPY WOUND/OSTOMY CARE
SURGICAL
CARDIOTHORACIC NEUROSURGERY
DENTAL SERVICES OPHTHAMOLOGY
DERMATOLOGY OPTOMETRY
EAR NOSE THROAT PODIATRY
GENERAL SURGERY ORTHOPEDIC
GYNECOLOGY UROLOGY
HAND/PLASTIC VASCULAR SURGERY
HEPATOBIILIARY

SPECIALITY (Continued)

SUPPORTING SERVICES

- | | | |
|--|--|--|
| <input type="checkbox"/> ANTICOAGULATION | <input type="checkbox"/> CHAPLAIN SERVICES | <input type="checkbox"/> PALLIATIVE CARE |
| <input type="checkbox"/> AUDIOLOGY | <input type="checkbox"/> HOSPICE CARE | <input type="checkbox"/> DME AND PROSTHETIC REQUESTS |
| <input type="checkbox"/> CARE COORDINATOR | <input type="checkbox"/> NUTRITION | <input type="checkbox"/> SKILLED HOME HEALTH |
| <input type="checkbox"/> TELEHEALTH | <input type="checkbox"/> PHARMACY SERVICES | |
| <input type="checkbox"/> CANCER COORDINATION | | |
| <input type="checkbox"/> CAREGIVER SUPPORT PROGRAM | | |

OTHER (Please Specify)

***SERVICE TYPE (Select One):**

- EVALUATE
 EVALUATE AND TREAT
 DIAGNOSTICS

***PROVIDER/VETERAN PREFERENCE FOR LOCATION OF SERVICE (Location Name):**

- VA FACILITY/PROVIDER
 NO PREFERENCE
 COMMUNITY FACILITY/PROVIDER

REQUIRED INFORMATION FOR ALL DME AND PROSTHETIC REQUESTS

HCPC FOR THE ITEM(S) BEING PRESCRIBED	ICD 10 CODES AND DIAGNOSIS	QUANTITY
BRAND, MAKE, MODEL OR PRODUCT, PART NUMBERS, ETC.		<input type="checkbox"/> DELIVER TO REQUESTING PROVIDER'S ADDRESS <input type="checkbox"/> DELIVER TO VETERAN'S HOME

EDUCATION COMPLETED TRAINING AND/OR FITTING WAS WAS NOT COMPLETED

**Education, training, and/or fitting of DME must be completed before DME is issued or mailed to Veteran. If not completed, DME will be mailed to requesting provider's address.*

MEDICAL JUSTIFICATION FOR THE DME

***REASON FOR REQUESTED SERVICE/SCHEDULING INSTRUCTIONS**

*PROVISIONAL DIAGNOSIS/DESCRIPTION

*ANTICIPATED DATE CARE BEGINS -
Clinically Indicated Date (mm/dd/yyyy)

*ANTICIPATED DATE CARE ENDS (mm/dd/yyyy)

*NUMBER OF VISITS (list number needed)

***ATTESTATION:**

I do hereby attest that the forgoing information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility and are able to be provided by the clinically indicated date (3) It is determined to be within the patients best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true and VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community.

I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, and providing continued care.

SIGNATURE:

DATE (mm/dd/yyyy)