Department of Veterans Affairs

# COMMUNITY CARE PROVIDER - REQUEST FOR SERVICE
## (Separate 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 |
|---|---|---|---|
| | | | |

***SUPPORTING DOCUMENTATION MUST ACCOMPANY THIS REQUEST***

### INITIAL AUTHORIZATION

| *UNIQUE IDENTIFIER: VA AUTHORIZATION/REFERRAL NUMBER | *REQUEST PRIORITY |
|---|---|
| | ☐ WITHIN 1 WEEK ☐ WITHIN 1 MONTH ☐ WITHIN 48 HOURS*<br>☐ OTHER *(Please Specify):*<br>**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

*SERVICE REQUESTED *(One Per Form)*

- ☐ ACUTE REHAB
- ☐ SURGICAL PROCEDURE
- ☐ IN-OFFICE PROCEDURE
- ☐ INPATIENT
- ☐ INPATIENT CARE
- ☐ OUTPATIENT
- ☐ OFFICE VISIT

TYPE OF REQUEST

- ☐ ADDITIONAL TIME
- ☐ ADDITIONAL VISITS
- ☐ 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
- ☐ CARDIOLOGY GENERAL
- ☐ CARDIOLOGY TESTING
- ☐ DEMENTIA
- ☐ ENDOCRINOLOGY
- ☐ GERIATRIC ASSESSMENT
- ☐ GASTROENTEROLOGY
- ☐ GYNECOLOGY
- ☐ HEMATOLOGY/ONCOLOGY
- ☐ HYPERTENSION
- ☐ INFECTIOUS DISEASE
- ☐ INFUSION THERAPY
- ☐ MENTAL HEALTH
- ☐ MATERNITY/OBSETRICS
- ☐ NEPHROLOGY
- ☐ NEUROLOGY
- ☐ PRIMARY CARE
- ☐ PAIN MANAGEMENT
- ☐ PULMONARY
- ☐ RADIATION ONCOLOGY
- ☐ RHEUMATOLOGY
- ☐ SLEEP STUDY/POLYSOMNOGRAPHY
- ☐ TRANSPLANT/REFERRAL CONSULT
- ☐ WOUND/OSTOMY CARE

SURGICAL

- ☐ CARDIOTHORACIC
- ☐ DENTAL SERVICES
- ☐ DERMATOLOGY
- ☐ EAR NOSE THROAT
- ☐ GENERAL SURGERY
- ☐ GYNECOLOGY
- ☐ HAND/PLASTIC
- ☐ HEPATOBILIARY
- ☐ NEUROSURGERY
- ☐ OPTHAMOLOGY
- ☐ OPTOMETRY
- ☐ PODIATRY
- ☐ ORTHOPEDIC
- ☐ UROLOGY
- ☐ VASCULAR SURGERY

**SPECIALITY** *(Continued)*

SUPPORTING SERVICES

- ☐ ANTICOAGULATION
- ☐ AUDIOLOGY
- ☐ CARE COORDINATOR
  - ☐ TELEHEALTH
  - ☐ CANCER COORDINATION
  - ☐ CAREGIVER SUPPORT PROGRAM
- ☐ CHAPLAIN SERVICES
- ☐ HOSPICE CARE
- ☐ NUTRITION
- ☐ PHARMACY SERVICES
- ☐ PALLIATIVE CARE
- ☐ PROSTHETICS
- ☐ SKILLED HOME HEALTH

OTHER *(Please Specify)*

| ***SERVICE TYPE** *(Select One):* | ***PROVIDER/VETERAN PREFERENCE FOR LOCATION OF SERVICE** *(Location Name):* |
|---|---|
| ☐ EVALUATE | ☐ VA FACILITY/PROVIDER |
| ☐ EVALUATE AND TREAT | ☐ NO PREFERENCE |
| ☐ DIAGNOSTICS | ☐ COMMUNITY FACILITY/PROVIDER |

***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)*