Department of Veterans Affairs

COMMUNITY CARE PROVIDER - REQUEST FOR SERVICE

(Separate Form Required for Each Service Requested)

If care is needed within 48 hours or if Veteran is at risk for Suicide/Homicide, please call the VA directly. *Indicates a required field

NOTE: Requests are approved/denied at VA Medical Center's discretion and supporting documentation must accompany each request.

VA FACILITY NAME:	VA FACILITY LOCATION:	*VA AUTHORIZATION/ REFERRAL NUMBER	TODAY'S DATE *(mm/dd/yyyy)*:

VETERAN INFORMATION

*VETERAN'S NAME *(Last, First, MI)*	*DATE OF BIRTH *(mm/dd/yyyy)*:

ORDERING PROVIDER INFORMATION

*ORDERING PROVIDERS NAME:	*ORDERING PROVIDERS NPI:	*ORDERING PROVIDERS 24-HR EMERGENCY CONTACT NUMBER *(for abnormal/critical findings)*:
*ORDERING PROVIDERS OFFICE PHONE:	*ORDERING PROVIDERS FAX NUMBER:	*ORDERING PROVIDERS SECURE EMAIL ADDRESS:

REQUESTED SERVICE - ONE SERVICE PER FORM

NEW REQUEST: **(Each request must be entered on a separate form)*

- ☐ PRIMARY CARE — PROCEDURE:
- ☐ SPECIALTY CARE
- ☐ MENTAL HEALTH — ICD 10:
- ☐ DURABLE MEDICAL EQUIPMENT *(DME) (Please enter information on Page 2)*
- ☐ LABORATORY/RADIOLOGY

ADDITIONAL REQUESTS WITH CURRENT PROVIDER:

- ☐ ADDITIONAL TIME WITH CURRENT PROVIDER
- ☐ ADDITIONAL VISITS WITH CURRENT PROVIDER

SERVICE TYPE *(Select one)*:

- ☐ DIAGNOSTIC TEST
- ☐ RADIOLOGY
- ☐ VISITS

ADDITIONAL INFORMATION:

VETERAN PREFERRED LOCATION OF SERVICE *(Location Name)*:

- ☐ VA FACILITY _____
- ☐ COMMUNITY FACILITY _____
- ☐ COMMUNITY PROVIDER _____
- ☐ NO PREFERENCE _____

***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.

*PROVIDER SIGNATURE:	*DATE *(mm/dd/yyyy)*: