|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Pre-Service | [ ]  |  | Elective | [ ]  |  | Urgent | [ ]  |
| Post-Service | [ ]  | Non-Elective | [ ]  | Non-Urgent | [ ]  |

 **Important:** Please read your insurer’s (for individuals with commercial insurance) or Vermont Medicaid’s (for Medicaid

 beneficiaries) specific instructions for completing this form.

|  |
| --- |
| **Patient/Member Information *(\* Required Field)*** |
| **\*First Name**  |  | **Middle Initial** |  | **\*Last Name** |  |
| **\*Health Insurance ID#** |  |  **\*DOB** |  |  **Gender Identity** |  |
| **\*Address** |  | **Apt.#** |  |
| **\*City** | **DF** | **\*State** |  |  **\*Zip** |  |  **\*Tel.** |  |
| **Referring/Requesting Provider Information *(\* Required)*** | **Rendering/Attending Provider Information *(\* Required)*** |
| **\*First Name** |       |  **\*Last Name** |       | **\*First Name**  |       | \***Last Name** |       |
| **\*NPI/TIN#** |  | **\*Specialty** |  | **\*NPI/TIN#**  |       |  **\*Specialty** |       |
| **\*Address** |  | **Suite** |  | **\*Address** |  | **Suite** |  |
| **\*City** |  | **\*State** |  | **\*City** |  |  **\*State** |  |
| **\*Tel.** |  |  **Fax#** |  | **\*Tel.** |  |  **Fax#** |  |
| **\*Office Contact/Person Completing Form**  |       |
| **\*Telephone No.**  |  | **Fax No.** |  |
| **Required Clinical Information (\* Required Field)** |
| **\*Date of Request** |  | **\*Is this request for Out-of-Network Services?**  |  **Y** | [ ]  |  **N** | [ ]  |
| \*Type of Service Requested *(check all that apply)* |
| **Services:** Obstetrics [ ] Medical Admit [ ]  Immunotherapy Treatment [ ] Mental Health/SUD [ ]  Surgery (including Oral Surgery) [ ] Oncology [ ]  Transplant [ ] Acupuncture [ ]  Chiropractic [ ]  | **Therapies:**Occupational Therapy [ ] Physical Therapy [ ] Speech Therapy [ ] Applied Behavior Analysis [ ]  |
| **Testing/Imaging:**Diagnostic Imaging [ ] Diagnostic Medical Test [ ]  | **Other:** |
|  DME | **[ ]**  |  SNF | **[ ]**  |  Home Health | **[ ]**  |  Vision/Glasses | **[ ]**  |
|  Home Infusion | **[ ]**  | Other *(please specify)* | **[ ]**  |  |
| **\*Date Diagnosed:** |       | \***Place of Service:** | Telehealth/Audio Only | **[ ]**  |
| Inpatient | **[ ]**  |  Outpatient | **[ ]**  |  Office | **[ ]**  | Other *(please specify)* | **[ ]**  |  |
| **\*Proposed Dates of Service:** | **From** |  | **\*Facility Where Service Will be Performed:**  |
| **To** |  |  |
| **\*Proposed Number of Inpatient Treatment Days** |  | **\*Proposed Number of Outpatient Treatment Visits** |  |
| **\*Primary Diagnosis** |  | **\*Primary Diagnosis Code** |  |
| **\*Secondary Diagnosis** |  | **\*Secondary Diagnosis Code** |  |
| **\*Name of Proposed Procedure** |  | **\*CPT/HCPCS or Revenue Code** |  |
| **\*Requested Durable Medical Equipment (DME)** |  |
| **\*DME CPT/HCPCS Code** |  | **\*DME Duration** |  |
| **\*DME Purchase Price** | **$**  | **\*DME Monthly Rental Price** | **$**  |
| **Additional Clinical Information Attached:** | **[ ]**  | **No. of pages:** | Enter Number. |