|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |