**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:** Click here to enter text. **Middle Initial:** . . . \***Last Name:** Click here to enter text. | | | | | | | |
| **\*Health Insurance ID#:** Click here to enter text. | | | | **\*DOB:** Enter date. | | **\*Gender: X  F  M** | |
| **\*Address:** Click or tap here to enter text. **Apt. #:** Click or tap here to enter text. | | | | | | | |
| **\*City:** Enter City. | | **\*State:** Choose an item. | | **\*ZIP:** Enter ZIP. | | **\*Tel.:** Enter Number. | |
| **Referring/Requesting Provider Information** | | | | **Rendering/Attending Provider Information** | | | |
| **First Name:** Enter text. **Last Name:** Enter text. | | | | **First Name:** Enter text. **Last Name:** Enter text. | | | |
| **NPI/TIN#:** Enter text. **Specialty:** Enter text. | | | | **NPI/TIN#:** Enter text. **Specialty:** Enter text. | | | |
| **Address:** Enter text. **Suite:** Enter text. | | | | **Address:** Enter text. **Suite:** Enter text. | | | |
| **City:** Enter City. | **State:** Choose an item. | | | **City:** Enter City. | | | **State:** Choose an item. |
| **Tel.:** Click or tap here to enter text. | **Fax:** Click or tap here to enter text. | | | **Tel.:** Click or tap here to enter text. | | | **Fax:** Click or tap here to enter text. |
| **Office Contact/Person Completing Form:** Click or tap here to enter text. | | | | | | | |
| **Telephone #:** Click or tap here to enter text. | | | | **Fax #:** Click or tap here to enter text. | | | |
| **Required Clinical Information (\* Required Field)** | | | | | | | |
| **\*Date of Request:**Click or tap to enter a date. | | | | **\*Is this request for Out-of-Network Services? Y  N** | | | |
| \*Type of Service Requested | | | | | | | |
| **Inpatient Care:**  Medical Admit:  Mental Health/SUD Admit:  OB:  Surgery:  Oral Surgery: | | | **Outpatient/Office Care:**  Acupuncture:  Chiropractic:  Infusion/Oncology Drugs:  Mental Health/SUD: | | **Therapies:**  Occupational Therapy:  Physical Therapy:  Speech Therapy: | | |
| **Testing:**  Diagnostic Imaging:  Diagnostic Medical Test: | | | **Other:**  DME: SNF:  Home Health:  Vision/Glasses:  Other  please specify: Click or tap here to enter text. | | | | |
| **\*Date Diagnosed:** Enter a date. | | | \***Place of Service:** Telehealth/Audio Only  Inpatient  Outpatient  Office  Other  - specify: Enter text. | | | | |
| **\*Proposed Dates of Service: From:** Enter a date.  **To:** Enter a date. | | | | **\*Facility Where Service Will be Performed:**  Click or tap here to enter text. | | | |
| **\*Proposed Number of Inpatient Treatment Days:** Number | | | | **\*Proposed Number of Outpatient Treatment Visits:** Number | | | |
| **\*Primary Diagnosis:** Click or tap here to enter text. | | | | **\*Primary Diagnosis Code:** Click or tap here to enter text. | | | |
| **\*Secondary Diagnosis:** Click or tap here to enter text. | | | | **\*Secondary Diagnosis Code:** Click or tap here to enter text. | | | |
| **\*Name of Proposed Procedure:** Click or tap here to enter text. | | | | **\*CPT/HCPCS or Revenue Code:** Click or tap here to enter text. | | | |
| **\*Requested Durable Medical Equipment (DME):** Click or tap here to enter text. | | | | | | | |
| **\*DME CPT/HCPCS Code:** Click or tap here to enter text. | | | | **\*DME Duration:** Click or tap here to enter text. | | | |
| **\*DME Purchase Price: $** Click or tap here to enter text. | | | | **\*DME Monthly Rental Price: $** Click or tap here to enter text. | | | |

**Additional Clinical Information Attached:**  (No. of pages: Click or tap here to enter text.).