**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.).