



AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

This information is collected under the authority of Title 38 1703, 1725 and 1728. In accordance with section 3507 of the Paperwork Reduction Act of 1995, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this invoice will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to authorize medical treatment and provide a means to bill for this service although private providers may also use local billing forms or UB (Uniform Billing) Forms 92. Submission of this form is voluntary and failure to respond will have no impact on benefits to which you may be entitled. Comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing the burden, may be addressed by calling the Health Benefits Contact Center at 1-877-222-8387.

1A. DATE OF ISSUE <i>(mm/dd/yyyy)</i>	1B. ISSUING OFFICE	1C. DATE OF ISSUE (Month, day, year)
<input type="text"/>	<input type="text"/>	<input type="text"/>
		1D. VETERAN'S NAME (First, middle initial, last) <i>(This is a mandatory field.)</i>
		<input type="text"/>
2. NAME OF PHYSICIAN OR FACILITY		3. VETERAN'S CLAIM NUMBER
<input type="text"/>		C- <input type="text"/>
		4. SOCIAL SECURITY NUMBER
		<input type="text"/>
5. AUTHORIZATION VALID		
FROM <i>(mm/dd/yyyy)</i>		TO <i>(mm/dd/yyyy)</i>
<input type="text"/>		<input type="text"/>

PART I - SERVICES AUTHORIZED		7. FEE
6. SERVICES SHOWN BELOW AUTHORIZED FOR PERIOD INDICATED IN ITEM 5 ABOVE. (See special provisions on back of form.)		\$
<input type="text"/>		<input type="text"/>
<input type="text"/>		<input type="text"/>
<input type="text"/>		<input type="text"/>
<input type="text"/>		<input type="text"/>
<input type="text"/>		<input type="text"/>

8. FEE SCHEDULE OR CONTRACT	9. AUTHORITY	9A.	10. ESTIMATED AMOUNT
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11. FISCAL SYMBOLS		12. AUTHORIZED BY (Name and Title)	
36 <input type="text"/> 0160.001		<input type="text"/>	

PART II - INVOICE		
13. DATE(S) OF SERVICE	14. DESCRIPTION OF SERVICE (If services furnished are identical to those authorized, enter the remark "As Authorized Above" in this column. Otherwise, itemize services.)	15. FEE CLAIMED AMOUNT
MONTH DAY YEAR	SERVICE FURNISHED	\$
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

15A. SOCIAL SECURITY NO OR EMPLOYER ID NO	Individual or organization furnishing service, enter billing date and amount claimed. (Continue billing on back if necessary.)	16. BILLING DATE <i>(mm/dd/yyyy)</i>	17. TOTAL CLAIMED
<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>

PART III - FOR VA USE ONLY				
ADMINISTRATIVE CERTIFICATION Payment of this will not cause payee to exceed maximum amount allowed. Services have been furnished as authorized or medically approved except as stated below.		AUDIT BLOCK		
		AMOUNT DUE	DATE	VOUCHER AUDITOR
		\$ <input type="text"/>	<input type="text"/>	<input type="text"/>
SIGNATURE AND TITLE		REMARKS		
		DATE		
<input type="text"/>		<input type="text"/>		

PART IV - ACCOUNTING BLOCK							
ION PAT NO	TC & SC	CPF	LIQ	AMT	1ST SA	\$	DATE/INITIALS
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
					2ND SA	\$	<input type="text"/>
					<input type="text"/>	<input type="text"/>	<input type="text"/>

