ALASKA VA

TRIBAL HEALTH SHARING AND REIMBURSEMENT AGREEMENT

2022 GUIDEBOOK

SERVING AMERICA'S VETERANS

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VA/Native Sharing and Reimbursement Agreement

The Sharing Agreements between Alaska VA Healthcare System (AVAHS) and the Alaska Tribal Health Programs set forth the terms and conditions under which AVAHS will authorize and reimburse the Native Health Program for direct care services provided to eligible Veterans.

This Guidebook outlines the process and procedures implemented to manage, maintain, and utilize the Agreement between partnering Native Health Programs and the Alaska VA Healthcare System. The goal of the Agreement is to increase access to healthcare for Alaska Veterans. Types of care provided under the Agreements include outpatient medical and mental health, inpatient care, ambulatory surgery, and other services available in the VA benefits package.

Veteran Enrollment Process/Eligibility Verification

A Veteran must be enrolled in the VA healthcare system prior to services being rendered for the AVAHS to authorize and/or reimburse for healthcare services. (*Note: Active Duty service is generally a requirement to access VA healthcare. Reserve or National Guard Veterans must have been called to Active Duty service or injured while active for training to obtain VA health care.*)

The enrollment/application form, VA Form 10-10 EZ **(pages 18-20)**, can be obtained online, by visiting, calling, or writing any VA health care facility or VBA benefits office. Depending on the method of application chosen by the Veteran, the following are ways the VA can receive and process the application:

(1) Applications with signature can be faxed to 907-257-6784.
(2) Applications being mailed to the facility should be sent to the following address:

Department of Veterans Affairs
Alaska VA Healthcare System
ATTN: Eligibility Department
1201 North Muldoon Road
Anchorage, AK 99504

(3) Online @ website: https://www.va.gov/health-care/apply/application/introduction
(4) Calling the Health Eligibility Center/Health Resources Center (HEC/HRC) at 877-222-VETS
(5) Emailed to VHAANCELIGIBILITY@VA.GOV

Most Veterans are required to provide a financial assessment (Means Test) as part of the enrollment process. Normally, Veterans that do not have a service-connected condition are required to complete this as part of the enrollment process. Only Veterans who qualify for benefits based strictly on income, such as VA travel coverage or co-pay waivers for medical care and medications, are required to update their means tests annually.

A DD 214 (Report of Separation) accompanying the request can help speed up the process of verification and enrollment; however, the DD 214 is not mandatory for submission and should not hold up sending in the 1010EZ. If a Veteran has misplaced or lost their DD 214, then the application can still be processed, but may delay the notification process. A Veteran can request another copy to be sent to them by completing SF-180, which is accessible at the Alaska VA Website (address on cover of

this document), in person at the Alaska VA, or also online at: http://www.archives.gov/Veterans/military-service-records/. The Health Eligibility Center in Atlanta, Georgia is the final authority of Veteran enrollment or status.

Unless there is an urgent need, please give the VA Healthcare system at least two weeks to process a Veteran for enrollment. A Veteran may check the status of their enrollment by calling the Alaska VA at 907-257-4700 (Option 3 and then 1) which will be answered by one of the clerks if available. The eligibility office will respond to messages within 24 hours. Another avenue of checking Veteran's enrollment/eligibility is to contact the Rural Health National Service helpline at 855-488-8441.

Note: Veterans enrolled and eligible for VA healthcare meet the minimum requirements for health care coverage under the Affordable Care Act.

AN/AI Direct Care Outpatient

Preauthorization is not required for AN/AI eligible Veterans receiving Direct care services from the partnering Native Health Program. A Veteran must be eligible for VA Healthcare services and the service must be included as part of the Veterans Benefits package.

AN/AI Referral Management to a Non-Native Facility

When a Native health care facility needs to refer an AN/AI Veteran for services not available within the AK Native health care system, this care **Must Be Preauthorized.** A "Community Care Provider Request for Service" should be faxed to Alaska VA Community Care Dept. at 907-257-7443. (**See document on pages 22-23)**

Clinical documentation must be attached to the "Request for Service" form. Clinical documentation should include at a minimum: diagnoses list, medication list, progress notes from the visit requesting the referral, and any ancillary testing results that the receiving provider would need to care for the patient.

Once the Community Care Dept. receives the "Request for Service" and clinical documentation, and it has been determined the Veteran is eligible for VA healthcare services, they will determine whether the care can be provided within a federal facility or if Non-VA care will be purchased. The Veteran will be called to coordinate the appointment time and/or to select a Non-VA provider. The Veteran will be mailed a copy of the authorization and an Authorization Letter. The Non-VA care provider will be faxed a copy of the authorization and the supporting clinical documentation.

Alaska Veterans Healthcare Clinics/Catchment Areas

The Alaska VA Healthcare System has clinics in the following areas:

- Anchorage VA Medical Center
- Fairbanks VA Community Based Outpatient Clinic (Ft. Wainwright in Bassett Army Community Hospital)
- Mat-Su VA Community Based Outpatient Clinic (Wasilla)
- Soldotna VA Community Based Outpatient Clinic and Homer VA Outreach Clinic
- Juneau VA Outreach Clinic

If a Non-AN/AI resides in a VA clinic catchment area and desires to utilize their VA benefits for their health care, s/he must go to one of the VA clinics for primary care and/or any specialty care unless referred out.

Non-AN/AI Pre-Authorization/Notification Process

For Non-AN/AI Veterans to be eligible for VA coverage for hospitalization, ER care, or preauthorized outpatient care, the Veteran must be enrolled with VA at the time service. **If enrollment has lapsed or the Veteran has never applied for VA health care, the care cannot be covered by the VA.** The Veteran may apply for enrollment when admitted, but it will take effect after discharge.

Preauthorized Outpatient Care:

All non-emergent care must be **preauthorized**. VA encourages vendors to submit routine requests and supporting documentation in advance, and as early as possible.

The process to request preauthorized outpatient care for Non-AN/AI Veterans is the same as requesting care for an AN/AI Veteran outside a Native facility. **See AN/AI Referral Management to a Non-Native Facility above.** The Community Care Provider Request for Service form should be submitted. The form can be located on **page 22-23** of this guidebook.

Upon approval the Non-AN/AI Veteran may be authorized for annual visits not to exceed 10*, prorated during the fiscal year*, (which could be used for primary care or behavioral health services), including simple labs and basic radiology.

If an office visit is for an emergent or urgent situation, notify the VA by utilizing the ER/Observation Alert Form (**located on page 24**) for us to document the encounter within our system as a possible ER/urgent care visit. If coded as emergent care, it will be reviewed as an emergency room visit and cannot be covered under an existing authorization.

Please read the Authorization Document carefully. VA will not be responsible for payment on any follow up appointments, diagnostic testing, or procedures that have not been pre-approved. The patient will be responsible for payment.

All VA rules and regulations pertaining to Veteran benefits, including healthcare, are established by Congress and administered by the Secretary of Veterans Affairs. These rules are subject to change.

Emergency Medical Services

Emergency medical services are not pre-authorized. However, medical services that are necessary on a prompt or emergent basis should be reported within 72 hours. Please submit notification of emergent medical care by letter, phone call, or fax. See **"VA ER/OBSERVATION ALERT"** on **page 24** of this guidebook is the best way to provide this notification. This alert will be required for the VA to cover emergency care and MEDEVAC under our primary payment authority. (The care will be processed as unauthorized care if the VA is not properly alerted and may not be coverable.) **If you need to determine eligibility immediately outside of standard business hours then contact the VA INTAKE OFFICE at the number shown below.** (***Note:*** *The VA Intake Office is currently closed between 4:30AM and 8:00AM until further notice*.) They can setup a physician to physician call with

our on-duty physician, determine patient stability for transfer, and facilitate transfer to the Joint Base Elmendorf-Richardson (JBER) Hospital when appropriate.

Telephone notifications:

VA Intake Office
@ 1-907-580-6421
Pager contact #: 907-580-7243, Ext. 0033

Alaska VA Community Care Dept. (Mon – Fri, 08:00AM - 4:00PM)
@ 1-888-353-7574, ext. 6904 or
907- 257-6904

Claims for emergency services are reviewed and verified by the VA prior to payment by our medical review board. The claims and the **emergency room report** should contain enough information to enable the review board to:

- Properly identify the Veteran.
- Determine the condition treated and amount of treatment already furnished.
- Confirm the need for the prompt or emergency treatment.
- Determine what further treatment, if any, is required.

If it is determined that the Veteran is eligible for prompt or emergent treatment, an authorization will be completed and forwarded to our Fiscal Service for payment. If it is determined that the emergency room visit did not meet the criteria for emergent medical services, an explanation of benefit letter will be sent to both the vendor and the Veteran stating the reason for denial.

Hospitalizations/Inpatient Admission

When Veterans are emergently admitted to a non-VA hospital, the VA should be notified within **72 hours** from the time of admission. This allows us the opportunity to verify eligibility or assist you in obtaining the necessary documents.

To be eligible for VA coverage for inpatient care, Veterans must be enrolled with the Alaska VA at the time of admission. ***If enrollment has lapsed or if the Veteran has never applied for healthcare benefits, the admission will not be covered by the VA.*** The Veteran may apply for enrollment at the time of admission, but it will go into effect until after discharge. We request admission notifications be done via fax at 1-907-257-6920.

See **"VA Inpatient ALERT"** on **page 25** of this guidebook.

By accepting VA coverage, the Veteran is subject to transfer to a Federal facility or to a contract facility if medically appropriate.

Considerations for each transfer:

- The patient's clinical stability
- Requests for surgical/invasive procedures

- Medical services needed
- Availability of such services at a Federal facility

Every effort will be made to respond to requests for authorization of medical services in an expeditious manner. VA will not transfer any patient who is assessed by the physician and documented as clinically unstable for transfer. Please see “**Transferring VA patients to another facility**” below for specific assistance with transfers.

Transferring VA patients to another facility

If you have a VA eligible patient that needs to be transferred to another facility (and the patient wishes to use his/her VA benefit), please call the **VA INTAKE OFFICE** *to transfer the patient to the JBER Hospital in Anchorage* (**see Telephone notifications on page 17 of this document**). The VA Intake Office will verify the patient’s eligibility for VA health care benefits and will facilitate transfer to the JBER Hospital if eligible.

The VA is required by law to utilize federal facilities first, and then contract services. We may purchase from other sources only if federal or contract services are not available.

In the case that a Veteran is transferred to the JBER Medical Facility, the VA Intake Office will alert the on-call internist who will then speak with the referring provider. Upon acceptance by the JBER internist, the VA Intake Office will notify the referring facility. This is the preferred method of patient referral, as federal law requires Veterans to be cared for at federal facilities when possible.

Many Southeast Alaska patients will be transferred to Seattle VA, not Anchorage VA. Medevac distances are similar and the range of services available at Seattle VA is much greater than Anchorage VA. In both above cases, the VA Intake Office can assist you in facilitating the transfer.

In all cases an accepting physician and a bed for the patient need to be acquired before medevac transportation can be arranged.

Care with Special Eligibility

The VA provides a robust Medical Benefits Package of health services and needs, but some categories/specialties of care do have specific eligibility criteria that must be met to receive them. Normally, it is dependent on the enrollment priority group or service-connected condition(s) assigned to a Veteran. Special reimbursement rates and eligibility criteria apply to the following services:

- Dental
- Certain Prosthetic items (hearing aids and eyeglasses)
- Long Term Care, to include nursing home care
- Transplant services
- In Vitro Fertilization

Maternity Benefits cover the Veteran’s obstetric care, in addition, care for the newborn child is provided for the first seven (7) days.

There are some services that are excluded from the VA Medical Benefits Package which include:

- Cosmetic surgery that is not medically necessary
- Abortions and abortion counseling
- Drugs, and biological/medical devices not approved by the Food and Drug Admin.
- Memberships in spas and health clubs
- Naturopathic medicine & massage therapy

Should there be any questions concerning a Veteran's eligibility for any of these services then please contact the Community Care Dept. 1-888-353-7574, ext. 6904. Your referral may require a call to another service for verification as well.

Travel Eligibility

Veterans must meet established eligibility criteria for travel related benefits. For a Veteran to be eligible for travel benefits they must meet one of the following criteria:

- Have a service-connected disability rating of 30 percent or greater
- Travel for treatment of a service-connected condition
- Receive a VA pension or income that does not exceed the Maximum Annual Pension Rate. (Please contact VA beneficiary travel to confirm income-based eligibility prior to travel.)
- Travel for a scheduled compensation and pension examination

If a travel-eligible Veteran must drive to a VA or Native facility for treatment and the distance exceeds 27 miles from the facility, the VA can reimburse for their travel. The Veteran must either present to the Alaska VA travel department for reimbursement, mail in the VA Form 3542, or fax the form to VA travel at 907-257-6982.

Veterans requiring air travel for their appointment will need the facility generating the request for the appointment to fax the travel request form (**see pages 27-28**) and relevant medical evidence to 907-257-6982. The VA travel office will validate travel eligibility and notify the Veteran of their travel arrangements. It is requested that the requesting facility give as much notice as possible (at least two weeks is preferred) to avoid any delays in arranging travel.

A Veteran may check the status of their travel arrangements by calling the Alaska VA at 907-257-4738, which will be answered by one of the clerks if available. The travel office will respond to messages within 24 hours.

Depending on the treatment needed and if an overnight stay is required, lodging and meals may also be reimbursable.

Pharmacy Services/Billing

The VA pharmacy provides needed medications accurately, safely, and in a timely manner. They monitor therapeutic outcomes of prescribed medications to minimize potentially negative effects. Prescriptions may be brought in person to the VA Pharmacy window, at 1201 North Muldoon Road, or mailed to the VA Pharmacy at the following address:

AK VA Healthcare System
Attn: 119 (Pharmacy)
1201 North Muldoon Road
Anchorage, AK 99504
PH: 907-257-4700 or 1-888-353-7574, Extension 4700
FAX: 907-257-6755

AVAHS will reimburse THP only for drugs on the formulary used by AVAHS. Requests for approval of non-formulary drugs will be submitted to VA Pharmacy and processed according to AVAHS policy on non-formulary drugs by mail to Alaska VA Healthcare System, Attn: 119 (Pharmacy), Chief, Pharmacy, 1201 North Muldoon Road, Anchorage, Alaska, 99504, telephone 1-907-257-4700, or fax 907-257-6755.

AVAHS will reimburse the THP at the current Wholesale Acquisition Cost (WAC) plus a $21.28 dispensing fee per pharmaceutical dispensed by the tribal sharing agreement partner. Pharmaceuticals for Veterans in an inpatient status are included in the per diem encounter rate.

AN/AI Veterans. AVAHS will reimburse THP for drugs provided to an AN/AI Eligible Veteran during outpatient visits and for prescriptions filled by THP. (**Note:** If the THP does not provide a particular medication needed by a Veteran, please inquire of the Alaska VA Healthcare System Pharmacy.)

Non-AN/AI Veterans. AVAHS will reimburse THP for drugs provided to a non-AN/AI Eligible Veteran during an outpatient visit and for an initial supply that shall not exceed a period of 30 days of prescribed drugs. THP shall refer Non-AN/AI Eligible Veterans to a VA facility or CMOP to fill prescriptions other than for the initial 30-day supply. Fax the prescription to the VA Pharmacy and the Pharmacist will enter the Veteran into the CMOP system. The Veteran can bring in the prescription if located in Anchorage and the Pharmacist will enter it into the CMOP for refills. Veterans can request refills from the CMOP themselves if prescribed by their provider by calling the 1-800 number written on the medication bottle label. Most refills for chronic medications are for 90 days.

To obtain a copy of the VA formulary list of medications, please call: 907-257-4700 or 1-888-353-7574, ext. 4700. It is also available at

https://www.pbm.va.gov/PBM/NationalFormulary.asp (Download the format that best meets your needs)

You can also do a single item formulary lookup at:

https://www.pbm.va.gov/apps/VANationalFormulary/

The VA Pharmacy staff is available Monday – Friday, 8:00 am – 4:30 pm.

CMS 1500 (paper) and 837P (EDI) claim requirements. Claim for reimbursement of medications for eligible Native Veterans must include the following information:

- HCPCS code – J3490
- Filling date
- Number of days supplied
- Quantity of drug
- Prescription number
- Doctor's name and address
- Generic drug name and strength
- Drug retail price/cost
- National Drug Code (NDC) and description
- NDC unit/basis of measurement:
  (Qualifier examples: F2-intertional unit/ ME- milligram/ ML- milliliter/ GR – gram/ UN- unit)
- Controlled substances must list a Drug Enforcement Administration (DEA) number

Non-Formulary Request. If a medication being billed is not on the VA Formulary, the billing THP must obtain a VA Non-Formulary Approval notice and annotate "PAO NF" (Prior Auth Obtained – Non Formulary) on the claim. On the CMS 1500, the PAO NF annotation should be noted in Box 23 and on EDI 837P write PAO NF on the EDI claims note section; then attach the approval in the EDI submission or mail to Northwest Region Payment Operations and Management (NW POM) address:

VA Portland Health Care System
ATTN: IHS/THP (10N20NPC)
1601 E Fourth Plain Blvd.
Vancouver, WA 98661

If the THP is mailing the VA Pharmacy Non-VA Formulary Approval to the NW POM in Vancouver, WA, that THP must also send an email to VHA13D01POMNWIHSTHPSupport@va.gov stating that the VA Non-Formulary Approval is being mailed. Additional options for sending a copy of the VA Pharmacy Non-VA Formulary Approval include sending it encrypted as an attachment to the above email or by faxing to 360-905-1772, ATTN: IHS/THP.

Pharmacy claims may now be submitted electronically. Any paper pharmacy claims must be submitted to Northwest Payment Operations and Management (POM) to the Address: VHA Office of Community Care P.O. Box 30780, Tampa, FL 33630-3780. *They should still include HCPCS code "J3490"; other codes will not be accepted.*

Here is an example of a correctly completed pharmacy paper claim (CMS 1500):

NDC | NDC Unit | NDC Description | HCPCS | Drug Strength

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
N400085113201 UN6.7 ZZALBUTEROL 90MCG 200D ORAL INHL							
09 04 14	09 04 14	22		J3490	AB	1070	6.7
N463304083005 UN45 ZZATORVASTATIN CA 80MG TABLET							
09 04 14	09 04 14	22		J3490	AD	1276	45
N400085461001 UN13 ZZFORMOTEROL/MOMETASONE 5MCG/200MCG							
09 04 14	09 04 14	22		J3490	AB	4893	13
N400172208380 UN90 ZZHYDROCHLOROTHIAZIDE 25MG TABLET							
09 04 14	09 04 14	22		J3490	AD	527	90
N400169183411 UN30 ZZINSULIN NPH U-100 INJ							
09 04 14	09 04 14	22		J3490	AC	1887	30
N400603421232 UN135 ZZLISINOPRIL 20MG TABLET							
09 04 14	09 04 14	22		J3490	AD	852	135

Here is an example of an 837P pharmacy EDI (Note: In the EDI information below, example entries are italicized, and entries left blank are bold/bracketed. All other content is hardcoded and should remain the same on submitted claims.):

Hierarchy	HL*2*1*22*0~
Subscriber Type	SBR*P*18* **[“Native beneficiary (THP 463 AIAN)” or a “Non-Native (THP 463)”]** ******CH~
Veteran Name/ SSN	NM1*IL*1***[LAST NAME]***[FIRST NAME]******[MI]***[SOCIAL SECURITY NUMBER]**~
Street Address	N3***[STREET ADDRESS]**~
City, State, Zip	N4***[CITY]***[STATE]***[ZIP CODE]**~
Line Number	LX*1~
HCPCS, Cost, and NDC unit, quantity	SV1*HC: J3490**82.56*UN*30****1:2~
Service Date(s) (D8 for single date) (RD8 for Range)	DTP*472*D8**20191108*~
Prescription Date	DTP*471*D8**20191115*~
Reference	REF*6R**000000469185230001*~
Line Note	NTE*ADD***[NDC Description/Drug name, days supply]**~
NDC Code	LIN**N4**76282042290*~
NDC Units	CTP*****30*UN*~
Prescription #	REF*XZ**1701092*~

Dental

Because Dental has special eligibility criteria, THPs must verify Veteran dental eligibility with the Dental Section in the Alaska VA Office of Community Care at 907-257-4845 or 907-375-2135 before requesting authorization. Messages are returned within one business day. The most common reasons

that Veterans may be eligible for dental care is because they have a 100% VA disability rating or they have a service-connected dental condition, but there are many other reasons Veterans may qualify for dental care. More information about VA Dental eligibility can be found at the following site: https://www.va.gov/health-care/about-va-health-benefits/dental-care/

Once eligibility is confirmed, THP Dental staff should fax an American Dental Association Dental Claim Form (**see page 33**) to the VA at 907-375-2146. If submitting a request for a subsequent appointment, the fax should also contain clinical notes. Dental imagery should be submitted via email to Brandi.Peacock@va.gov. (**Note:** Dental notes with PII may only be submitted to VA by fax.) For more information on how to correctly submit an ADA Dental Claim Form to VA, please request further instruction from the Alaska VA Community Care Dental Section.

Once received, the VA Dental Chief will review all requests from THPs for approval. (**Note:** VA may not reimburse for services provided without authorization. Urgent visits still require approval prior to service; contact the Dental Section to expedite processing at 907-257-4845.) Upon approval, VA will notify vendor to schedule the Veteran. Once the Veteran is scheduled and VA notified, VA will fax the ADA Dental Claim back with a VA authorization number and signature from an approving official.

After completing a dental appointment, THPs must fax clinical notes to 907-257-7443 for documentation/recordkeeping. Vendors should send ADA claims electronically or by paper claim as indicated in the following section. *(**Note:** Because the ADA claim form is faxed multiple times before it will be submitted for reimbursement, if using paper, it is highly recommended to use a new claim form with information typed to ensure it will be correctly read and processed by VA document scanning systems. Since authorization is on file, the absence of a VA signature on the claim will not impact processing.)*

Billing/Reimbursement

The bill paying process for Alaska claims follows standard billing practices with one exception; the code identifying whether a Veteran is a Native beneficiary (THP 463 AIAN), or a Non-Native (THP 463) must be included (**see billing examples on pages 29-33**). Care provided by a Community Health Aide should also include "CHA" in the authorization number (Example: "THP 463 CHA"). Claims are then submitted to the VHA Office of Community Care in Tampa, FL, and processed in our regional Payment Operations and Management (POM) facility in Vancouver, WA.

Note: If the "THP 463 AIAN" or "THP 463" is not included on the claim form—under "Prior Authorization Number" on the CMS-1500 and "Treatment Authorization Codes" on the UB-04—the claim may be misdirected and improperly paid or rejected *(EOB reasons for rejection "IHS No Station/Contract," "IHS/THP Add AIAN Status," or for provider credentialing usually indicate that the proper code was not used)*.

Claims should be filed within one year of the date of service. The VA will make payment on electronic claims within 30 days and 45 days for paper claims. For facility charges and services, electronic claim submission is the preference due to processing speed, but all claims for services must be submitted either electronically (EDI) or by mail. Please do not fax claims because our system utilizes OCR software to transfer the data appropriately for timely processing.

Address for **ALL** paper claims (regardless of whether the Veteran is Native or Non-Native):

VHA Office of Community Care
P.O. Box 30780
Tampa, FL 33630-3780

Incomplete claims or claims missing information will delay processing and could result in either claim denials or rejects. We process all claims off invoices, not statements. To process an invoice in a timely manner, the VA is requesting that each invoice (original not photocopy) UB-04 or CMS 1500 contain the following:

Required Information	CMS 1500 (HCFA)	CMS 1450 (UB)	Dental Claims
Contract/Agreement #	Box 19	Box 80	Box 35
Annotate THP • **THP 463 Native (for AI/AN Veteran)** • **THP 463 (Non-Native Veteran**	Box 23	Box 63	Box 16

Claims must contain:

- Name, Address, and SSN of the Veteran
- Name, Address, and Tax ID of the Vendor
- Name, Address, or facility where services were rendered
- Date of Service
- Detailed itemization, appropriate CPT and/or HCPCS codes for each service provided, and ICD-9-CM (diagnosis) code(s).
- *For Dental claims only:* VA Authorization number in Box (due to unique eligibility requirements)

Electronic billing/EDI (Electronic Data Interchange): Facilities submitting EDI claims will need to register with Change Healthcare (formerly Emdeon) by phone or web: 800-845-6592 or https://www.changehealthcare.com/support/customer-resources/payer-lists.

Once registered, billing staff should ensure that "THP 463 Native (for AI/AN Veteran) or THP 463 (Non-Native Veteran)" is added to the SBR03 segment of the 837 for proper routing through the VA. The VA payer ID is different for medical and dental claims:

- "12115" for medical claim submission
- "12116" for dental claim submission

Payment will be made based on the approved Encounter rate for outpatient visit or inpatient hospitalization as published in the Federal Register. Community Health Aide services will be reimbursed at 85% of the Encounter rate. If a Native Health Program seeks reimbursement under the Sharing Agreement, such payment shall be considered payment in full and the Native Health Program may not seek reimbursement for such care from entities or individuals other than the VA.

For Claims Status and Payment Inquiry:

eCAMS Provider Portal (ePP) allows registered THP providers to research the status of claims received by VA and being processed in the VA's Electronic Claims Adjudication Management System (eCAMS). THP providers may register for ePP (https://www.occepp.fsc.va.gov/) to view the VA payment information and claim status. ***Note:*** *If the ePP is down and claims information is required, please contact NW Payment Operations and Management at 360-696-4061, ext. 34367 for claims status or NDSC Provider Portal Customer Support at 877-353-9791 (Select Option 1)/ VAFSC.EOB4U@va.gov for documentation related to claims payment.*

Customer Engagement Portal (CEP) is the legacy system that allows registered THP providers to research the status of claims received by VA. THP providers may still use CEP (https://www.cep.fsc.va.gov/) to view the VA payment information and claim status until further notice; however, it is unknown how long it will remain available as a resource.

For questions regarding submitted health care claims, contact Northwest Payment Operations and Management (NW POM)

- Claims Payment Processing Call Center at **877-881-7618** between the hours of 4 AM and 4:30 PM (AKST), Monday thru Friday. When contacting the call center, identify as a non-CCN provider (option 2) and use the zip code for Vancouver, WA, to be directed to the correct operator: **98661**.
- For questions and issues with submitted THP claims, email NW POM at VHA13D01POMNWIHSTHPSupport@va.gov.

Copayment/Third Party Billing

The Co-Payment requirement has been waived for Native Veterans. The Co-payment required for Non-Native Veterans will be determined by the VA, and the Veteran will be billed by the VA.

Co-payment amounts are normally $15.00 for primary care visits, and $50.00 for a specialty visit.

Pharmacy co-payments are also required for certain Veterans.

VA will pursue third party billing when appropriate for services reimbursed to the Tribal Health Programs.

Common VA Departments and Extensions:

The 1-888 phone numbers below can also be reached by dialing
1-907-257-xxxx (xxxx = extension)
Normal VA Duty Hours: Monday – Friday 8:00 a.m. to 4:30 p.m.

Rural Health

Ric Epperson, Rural Health Program Manager	1-888-353-7574, ext. 5460
Phil Hokenson, RH Outreach Coordinator (Fairbanks)	1-907-450-9013
Sharon Strutz-Norton, RH Quality Mgmt. Nurse (Homer)	1-907-235-0275
George Bennett, Rural Veteran Liaison (Sitka)	1-907-966-8776
Rural Health Eligibility National Service Helpline	1-855-488-8441

Dental Service	1-888-353-7574, ext. 4940
Diabetes Coordinator	1-888-353-7574, ext. 4828
Family Caregivers Program	1-888-353-7574, ext. 7439/4922
Laboratory	1-888-353-7574, ext. 4870
Long Term Care	1-888-353-7574, ext. 4718
Military Sexual Trauma Coordinator	1-888-353-7574, ext. 4908
My HealtheVet Coordinator	1-888-353-7574, ext. 7496
**** ONE STOP SHOP****	**1-888-353-7574, ext. 5463**
Pharmacy	1-888-353-7574, ext. 4805
Prosthetics	1-888-353-7574, ext. 4930
Social & Behavioral Health Service	1-888-353-7574, ext. 4854
Suicide Prevention Coordinator	1-888-353-7574, ext. 4846
Telehealth/Triage	1-888-353-7574, Option #3
Veteran Eligibility and Enrollment	1-888-353-7574, ext. 3323
Veteran Travel	1-888-353-7574, ext. 4738
Veterans Benefits (ex: Disability, Pension, VR&E, home loans)	1-800-827-1000

**** Resolve problem issues at lowest level, route to appropriate dept, and troubleshoot****

Other Alaska Veterans Healthcare Clinics/Offices:

Fairbanks VA Medical Clinic on Ft. Wainwright	1-907-370-1401
Fairbanks RN Care Manager	1-907-370-1410
Fairbanks Fax	1-907-257-4998
Soldotna VA Clinic	1-907-420-3200
Soldotna RN Care Manager	1-907-420-3223
Soldotna Fax	1-907-420-3210
Mat-Su VA Clinic	1-907-631-3100
Mat-Su VA Toll Free	1-866-323-8648
Mat-Su VA Fax	1-907-631-3101
Juneau VA Outreach Clinic	1-907-796-4300
Juneau Outreach Toll Free	1-888-308-7890
Juneau Outreach Fax	1-907-796-4301

Phone Numbers for Community Care Dept.

The 1-888 phone numbers below can also be reached by dialing
1-907-257-xxxx (xxxx = extension)
Normal VA Duty Hours: Monday – Friday 8:00 am to 4:30 pm

Authorizations/Outpatient Patient Services Asst. (PSA) 1-888-353-7574, ext. 6904
Authorization Request Fax Line 1-907-257-7418
Michelle Wyatt, Chief, Community Care Dept. 1-888-353-7574, ext. 4862
(On detail outside of Department until November 2022)
Julie Reloza-Keating, CC Nurse Manager 1-888-353-7574, ext. 4733
(Acting Chief of Community Care Dept. until November 2022)
Lisa Smith, CC UM Nurse Manager 1-888-353-7574, ext. 3740
Carmencita "Mentzi" Canlas, CC Asst. Nurse Manager 1-888-353-7574, ext. 6947
Samantha Gentry, CC UM Assistant Nurse Manager 1-888-353-7574, ext 4753
Utilization Management Fax 1-907-257-6920
Wanda Zangrilli, Traveling Veterans/Transplant Coordinator 1-888-353-7574, ext. 6743
Alaska VA Community Care – Dental POD TEAM
Brandi Peacock, AMSA 1-907-257-4845
Mandy Foxworth, RN, BSN 1-907-375-2135

**Community Care Dept./Authorizations Message Line 1-888-353-7574, ext. 3202

Messages left on the Message Line are checked daily and returned with 24 hours.

Other Important Numbers to keep handy

Telehealth/Triage (8:00 am–4:00 pm) Veterans' health concerns:

1-888-353-7574, ext. 4710

Telehealth/Triage during non-duty hour's 24 hr. off-site nurses to answer Veterans' health concerns/questions:

1-888-353-7574, option 3

VA INTAKE OFFICE – for emergencies, inpatient admissions, VA transfers, after hour questions

Direct Dial: **1-907-580-6421**

Toll Free #: **1-877-817-3885**

VA INTAKE OFFICE Pager: **907-580-7243, ext. #0033**

VETERANS CRISIS LINE: 1-800-273-8255, Press 1

**** ONE STOP SHOP **** **1-888-353-7574, ext. 5463**

Provides one phone number to help resolve and troubleshoot patient or vendor issues at the lowest possible level. If you are having an issue and not sure who to call.

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date: 06/30/2024

Department of Veterans Affairs

VA DATE STAMP
(For VHA Use Only)

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)

☐ **REGISTRATION** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU SPANISH, HISPANIC,OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE ☐ TRANSMALE/TRANSMAN/FEMALE-TO-MALE ☐ TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE ☐ CHOOSE NOT TO ANSWER	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ CHOOSE NOT TO ANSWER

6. SOCIAL SECURITY NO.	7A. DATE OF BIRTH *(mm/dd/yyyy)*	7B. PLACE OF BIRTH *(City and State)*	8. RELIGION

9A. MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP CODE	9E.COUNTY

9F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	9G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	9H. E-MAIL ADDRESS *(optional)*

10A. HOME ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

11. CURRENT MARTIAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

12A. NEXT OF KIN NAME	12B. NEXT OF KIN ADDRESS	12C. NEXT OF KIN RELATIONSHIP

12D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	12E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)*	13. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

14. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	15. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(mm/dd/yyyy)*	1C. FUTURE DISCHARGE DATE *(mm/dd/yyyy)*	1D. LAST DISCHARGE DATE *(mm/dd/yyyy)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE ________ %		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

APPLICATION FOR HEALTH BENEFITS
Continued

VETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NUMBER

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER

3. POLICY NUMBER

4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*
☐ YES ☐ NO

6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?
☐ YES ☐ NO

6B. EFFECTIVE DATE *(mm/dd/yyyy)* ____________________

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*

1C. SELF-IDENTIFIED GENDER IDENTITY
☐ MALE ☐ FEMALE
☐ TRANSMALE/TRANSMAN/FEMALE-TO-MALE
☐ TRANSFEMALE/TRANSWOMAN/MALE-TO-FEMALE
☐ CHOOSE NOT TO ANSWER

1D. DATE OF MARRIAGE *(mm/dd/yyyy)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*

2B. CHILD'S SOCIAL SECURITY NO.

2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one).*
☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(mm/dd/yyyy)*

1C. COMPANY NAME. *(Complete if employed or retired)*

1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*

1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

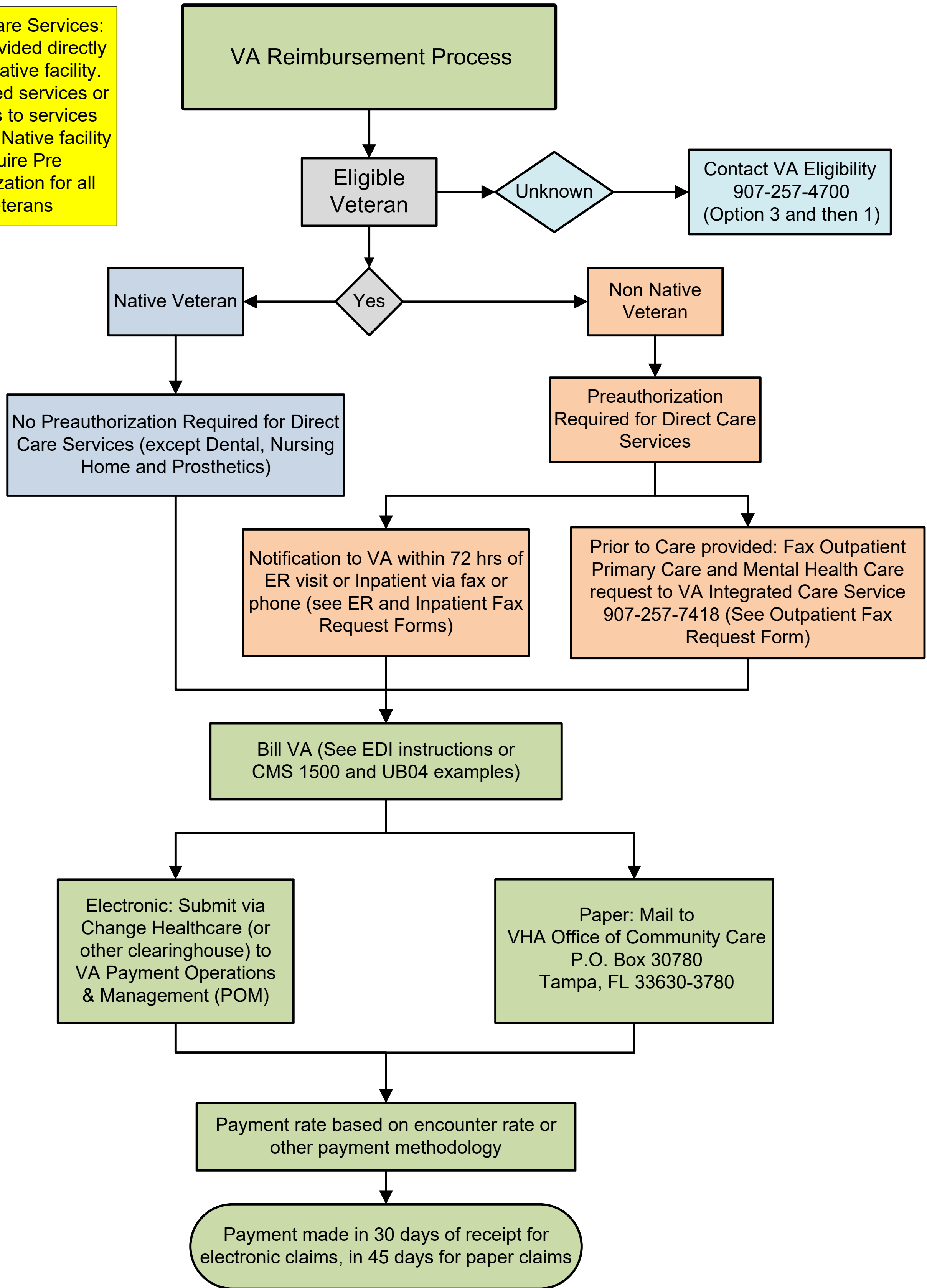
ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

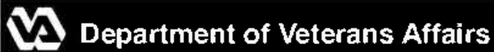
ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT
(Sign in ink) ______________________________

DATE *(mm/dd/yyyy)* ____________________


Direct Care Services: Care provided directly by the Native facility. Contracted services or referrals to services outside a Native facility require Pre Authorization for all Veterans
VA Reimbursement Process
Eligible Veteran
Unknown
Contact VA Eligibility 907-257-4700 (Option 3 and then 1)
Yes
Native Veteran
Non Native Veteran
No Preauthorization Required for Direct Care Services (except Dental, Nursing Home and Prosthetics)
Preauthorization Required for Direct Care Services
Notification to VA within 72 hrs of ER visit or Inpatient via fax or phone (see ER and Inpatient Fax Request Forms)
Prior to Care provided: Fax Outpatient Primary Care and Mental Health Care request to VA Integrated Care Service 907-257-7418 (See Outpatient Fax Request Form)
Bill VA (See EDI instructions or CMS 1500 and UB04 examples)
Electronic: Submit via Change Healthcare (or other clearinghouse) to VA Payment Operations & Management (POM)
Paper: Mail to VHA Office of Community Care P.O. Box 30780 Tampa, FL 33630-3780
Payment rate based on encounter rate or other payment methodology
Payment made in 30 days of receipt for electronic claims, in 45 days for paper claims

FAX TO: 907.375.2146



COMMUNITY CARE PROVIDER - REQUEST FOR SERVICE

(Separate Form Required for Each Service Requested)

If care is needed within 48 hours or if Veteran is at risk for Suicide/Homicide, please call the VA directly. *Indicates a required field

NOTE: Requests are approved/denied at VA Medical Center's discretion and supporting documentation must accompany each request.

VA FACILITY NAME:	VA FACILITY LOCATION:	*VA AUTHORIZATION/ REFERRAL NUMBER ("Initial" or VA Auth #)	TODAY'S DATE *(mm/dd/yyyy)*:
Alaska VAMC	Anchorage		

VETERAN INFORMATION

*VETERAN'S NAME *(Last, First, MI)* (full name / include last 4 of SSN)	*DATE OF BIRTH *(mm/dd/yyyy)*:

ORDERING PROVIDER INFORMATION

*ORDERING PROVIDERS NAME: Provider's full name/THO information	*ORDERING PROVIDERS NPI: NPIs for Provider & Facility	*ORDERING PROVIDERS 24-HR EMERGENCY CONTACT NUMBER *(for abnormal/critical findings)*:
*ORDERING PROVIDERS OFFICE PHONE: For referral questions	*ORDERING PROVIDERS FAX NUMBER:	*ORDERING PROVIDERS SECURE EMAIL ADDRESS:

REQUESTED SERVICE - ONE SERVICE PER FORM

NEW REQUEST: **(Each request must be entered on a separate form)*

- ☐ PRIMARY CARE
- ☐ SPECIALTY CARE
- ☐ MENTAL HEALTH
- ☐ DURABLE MEDICAL EQUIPMENT *(DME) (Please enter information on Page 2)*
- ☐ LABORATORY/RADIOLOGY

PROCEDURE:

ICD 10: Dx is REQUIRED

ADDITIONAL REQUESTS WITH CURRENT PROVIDER:

- ☐ ADDITIONAL TIME WITH CURRENT PROVIDER
- ☐ ADDITIONAL VISITS WITH CURRENT PROVIDER

SERVICE TYPE *(Select one)*:

- ☐ DIAGNOSTIC TEST
- ☐ RADIOLOGY
- ☐ VISITS

ADDITIONAL INFORMATION:

INDICATE SPECIALTY HERE. IF REQUESTING TESTING, PLEASE INDICATE THAT IN THIS SPACE.

VETERAN PREFERRED LOCATION OF SERVICE *(Location Name)*:

- ☐ VA FACILITY ____________________
- ☐ COMMUNITY FACILITY ____________________
- ☐ COMMUNITY PROVIDER ____________________
- ☐ NO PREFERENCE ____________________

***ATTESTATION:**

I do hereby attest that the forgoing information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility and are able to be provided by the clinically indicated date (3) It is determined to be within the patients best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true and VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community.

I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, and providing continued care.

*PROVIDER SIGNATURE:	*DATE *(mm/dd/yyyy)*:

THIS FORM MUST BE COMPLETED IN FULL FOR PROCESSING

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS

*****REQUIRED INFORMATION FOR ALL DME AND PROSTHETIC REQUESTS**

Please see https://www.va.gov/COMMUNITYCARE/providers/Service_Requirements.asp for URGENT DME requests.

NOTE: Failure to thoroughly complete the RFS for DME will result in delayed patient care and prevent the VA from DME fulfillment.

DME AND PROSTHETICS INFORMATION

*HCPCS FOR THE ITEM(S) BEING PRESCRIBED:	*BRAND, MAKE, MODEL, PART NUMBERS:	*MEASUREMENTS:

*QUANTITY: *ICD 10:

*PROVISIONAL DIAGNOSIS:

*DELIVERY AND/OR PICKUP OPTIONS:
- ☐ DELIVER TO ORDERING PROVIDERS ADDRESS
- ☐ DELIVER TO VETERANS HOME
- ☐ VETERAN WILL PICK UP AT THE VA MEDICAL CENTER
- ☐ DELIVER TO COMMUNITY VENDOR FOR DELIVERY AND SET UP OF DME

DURABLE MEDICAL EQUIPMENT (DME) EDUCATION AND TRAINING

EDUCATION, TRAINING, AND/OR FITTING:
☐ WAS COMPLETED ☐ WAS NOT COMPLETED

**Education, training, and/or fitting of DME must be completed before DME is issued or mailed to Veteran. If not completed, DME will be mailed to requesting provider's address.*

REQUESTING PROVIDER'S ADDRESS:

MEDICAL JUSTIFICATION FOR THE DME

HOME OXYGEN INFORMATION

PA02 AT REST:	02SAT AT REST:	OXYGEN FLOW RATE:	EXTENT OF SUPPORT *(Continuous, Intermittent, Specific Activity):*

OXYGEN EQUIPMENT *(Stationary/Portable):*	DELIVERY SYSTEM *(Cannula, Mask, Other):*

THERAPEUTIC FOOTWEAR ASSESSMENT INFORMATION

Prescription for therapeutic footwear for severe or gross foot deformity which cannot be accommodated with conventional footwear.

Fill out the applicable information below:

☐ LEFT FOOT ☐ RIGHT FOOT ☐ BILATERAL
☐ PREFABRICATED THERAPEUTIC FOOTWEAR
☐ CUSTOM THERAPEUTIC FOOTWEAR

DESCRIBE FOOT DEFORMITY:

NOTE: Only patients who are experiencing medical conditions noted in the risk scores can be prescribed therapeutic/diabetic footwear.

Prescription for prefabricated therapeutic footwear due to disease pathology resulting in neuropathy or peripheral artery disease.

Check appropriate diabetic/amputation risk score below:

☐ **Risk Score 2**: patient demonstrated sensory loss (inability to perceive the Semmes-Weinstein 5.07 monofilament), diminished circulation as evidenced by absent or weakly palpable pulses, foot deformity, or minor foot infection, and a diagnosis of diabetes.

☐ **Risk Score 3**: patient demonstrated peripheral neuropathy with sensory loss (i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament), and diminished circulation, and foot deformity, or minor foot infection and a diagnosis of diabetes, or any of the following by itself: (1) Prior ulcer, osteomyelitis or history of prior amputation; (2) Severe Peripheral Vascular Disease (PVD) (intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration or gangrene); (3) Charcot's joint disease with foot deformity; and (4) End Stage Renal Disease.

***ATTESTATION:**

I do hereby attest that the forgoing information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility and are able to be provided by the clinically indicated date (3) It is determined to be within the patients best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true and VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community.

I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, and providing continued care.

*PROVIDER SIGNATURE:	*DATE *(mm/dd/yyyy)*:

VA ER / OBSERVATION ALERT

For more information, contact Utilization Management
Rachel 907.375.2189 / Rowena 907.375.2114
Instructions: complete this form and attach facesheet and ER notes.
Fax packet to: 907.257.6920
*****INCOMPLETE PACKETS WILL BE RETURNED FOR COMPLETION, AND MAY DELAY AUTHORIZATION*****

TODAY'S DATE: ______________________

HOSPITAL NAME/LOCATION: ____

HOSPITAL PHONE/ FAX: ____

ER PHYSICIAN: _____________________________________ PHYSICIAN NPI#: ______________________

DATE OF SERVICE: _________________

VETERAN'S FULL NAME: __________________________________ DATE OF BIRTH: ____________________

VETERAN'S FULL SSN: ____________________________________

DIAGNOSIS/CHIEF COMPLAINT: ____

ADDITIONAL INSURANCE INFORMATION: ____

VA INPATIENT ALERT

For more information, contact UtilizationManagement :

Rachel 907.375.2189 / Rowena 907.375.2114

Instructions: complete this form and attach admission facesheet. Fax packet to: 907.257.6920

*****INCOMPLETE PACKETS WILL BE RETURNED FOR COMPLETION, AND MAY DELAY AUTHORIZATION*****

DATE: ___________________________

HOSPITAL NAME: ____

HOSPITAL CONTACT / FAX: ____

ADMITTING PHYSICIAN (FULL NAME): ____

PHYSICIAN'S NPI: ____

ADMISSION TYPE: ER DIRECT SCHEDULED

DATE PATIENT IN ER IF DIFFERENT THAN ADMIT DATE: ______________________________

DATE OF ADMISSION: _____________________________

VETERAN'S FULL NAME: ____

FULL SSN: ______________________________ **DATE OF BIRTH:** ____________________

DIAGNOSIS: ____

SPECIALTY: MED SURGERY PSYCH REHAB

ADDITIONAL INSURANCE INFORMATION: ____

Requesting VA Travel

Veteran or Representative requests travel

Fax Travel Request Form along with verification of appointment date and time to
Fax # 907-257-6982
Or call 907 257-4700 option 6 then option 1

VA Travel Staff will determine if Veteran is Travel Eligible

YES

VA Travel will notify Veteran or Representative of travel itinerary within three to five days of appointment

Note any approved reimbursable expenses require receipts can be mailed or paid in person at VA Anchorage

NO

VA Travel will utilize VA VTS funds for Veteran travel if funds available

VA TRAVEL REQUEST FORM

Requesting Facility Information

Name of Facility: ___________________________________ Request Date: _________________

Name of Requesting Official: ____

Contact Phone: (_____) _____ - _________

Email Address: ______________________________________

Patient Information

Veteran's Last Name: ______________________ Veteran's First Name: ______________________
Last 4 of Veteran's Social Security Number: __________________
Permanent Address: ____
Temporary Address (if applicable): ____
Home Phone: (_____) _____ - _________ Cell Phone: (_____) _____ - _________
Select Specialty: MED _____ SURG _____ PSYCH _____
Appointment Date and Time: ______________________
Facility of Appointment: ________________________________ City: _________________________
Will patient need an escort? Yes or No Name of escort: ___________________________________

Please complete escort request form.

Travel Information

Date of Travel (mm/dd/yyyy)	FROM (Departure Location)	TO (Arrival Location)	Mode of Travel A = Air S = Sea T = Train G = Ground Transport

---

FOR BENEFICIARY TRAVEL CLERK ONLY

Received Date: ___________________		Is Veteran eligible for travel benefits? (circle one): Yes No Is Veteran eligible for VTS? (circle one): Yes No
Date contacted Veteran	Contacted by	Comments

Travel Office: 907-257-4738 Fax: 907-257-6982

<u>Special Travel Request</u>

TO: BENEFICIARY TRAVEL OFFICE

PATIENT: ____

<u>NEEDS A NON-MEDICAL ESCORT DUE TO THE FOLLOWING:</u>

______DEMENTIA/MEMORY LOSS

______BLIND

______UNABLE TO TRANSFER SELF FROM WHEELCHAIR

______NEED FIR OIST-OP ATTENDANCE

<u>NEEDS A FLIGHT INSTEAD OF DRIVING DUE TO THE FOLLOWING:</u>

______DOCUMENTED CHRONIC BACK PAIN

______UNABLE TO DRIVE DUE TO THE FOLLOWING MEDICATIONS:

____

______SEVERE ANXIETY/PTSD

______INSOMNIA (HIGH RISK DRIVER)

______KNEES/LEG DISABILITY – (SPECIFIC PROBLEM) _______________________

______VISION/HEARING DIFFICULTIES

______TRAUMATIC ARTHRITIS

______CANNOT SIT FOR EXTENDED PERIODS OF TIME due to: __________________

______OTHER: ____

THIS IS AUTHORIZED BY THE MEDICAL PROVIDER LISTED BELOW:

And subject to review by Chief of Staff

EFFECTIVE DATE: ______________________________

(THIS REQUEST IS VALID FOR 1 YEAR FROM THE DATE SIGNED)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

THP 463-AIAN

23 NATIVE

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

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SIGNED

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

THP 463

23 NON NATIVE

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

OB04 AIAN

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME | 9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

PAGE ___ OF ___ CREATION DATE TOTALS

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 Native

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

THP 463-AIAN

66 DX | 67

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 | 76 ATTENDING NPI QUAL LAST FIRST

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

26

UB04 Non-Native

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME | 9 PATIENT ADDRESS

10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

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PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 Non Native

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

THP 463

66 DX | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 | 76 ATTENDING NPI QUAL LAST FIRST

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

27

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- ☐ Statement of Actual Services
- ■ Request for Predetermination/Preauthorization
- ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

VA AUTH #

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

NAME:
ADDRESS:
PHONE:

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

SSN

16. Plan/Group Number

THP 463 / THP 463 AIAN

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A ______________ B ______________ C ______________ D ______________

(Primary diagnosis in "**A**")

31a. Other Fee(s)

32. Total Fee $0.00

35. Remarks

APT: DATE/TIME: VA CONTRACT #: VA260-12-A-____

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X ____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X ____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

VENDOR'S NAME
PHONE:
FAX:
NPI:

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X ____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID

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J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
or go online at adacatalog.org