**Important:** All requests should be faxed or emailed with clinical documentation that supports medical necessity.

**Please fax mental health requests to 855-275-1212 and clinical requests to 802-879-5963 or email to** [**AHS.DVHAClinicalUnit@vermont.gov**](mailto:AHS.DVHAClinicalUnit@vermont.gov)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 Identity:** Enter text. | |
| **\*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 (\* Required)** | | | | **Rendering/Attending Provider Information (\* Required)** | | | |
| **\*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 (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: 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. | | | |