**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**

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| --- |
| **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. |