HUMANA VETERANS
HEALTHCARE SERVICES

★★★★★

VETERAN AUTHORIZATION REQUEST FORM

SECTION I: PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB:	SSN:
Address:	City:		State:	Zip:

SECTION II: PROVIDER INFORMATION

Requesting Physician:	Contact Person:	Facility Name:
Physician Tax ID:	Phone:	Facility Tax ID:
Specialty: (type)	Fax:	Contact Person:

SECTION III: REQUESTED SERVICES INFORMATION

☐Radiology / Imaging : CPT code _____	☐Inpatient Admission: ☐Acute Care ☐Rehab ☐SNF
☐In-Office Procedure: CPT code(s) _____	☐Labs
☐Surgical / Diagnostic Procedure: CPT code _____	☐Speech Therapy
☐ Inpatient (**must complete section VI**) ☐ Outpatient	☐PT / OT
☐Additional Office Visits (listed # needed)	☐Other

SECTION IV: ADDITIONAL INFORMATION

ICD 9 Diagnosis Code / Description of Diagnosis:

CPT Code Descriptions:

Service Date (if known):

Other:

SECTION V: CLINICAL INFORMATION

To avoid delays, include appropriate documentation such as office notes, current treatment plan, clinical history, laboratory results, radiology results and/or medications to support the medical necessity of services requested. Additional Information submitted: ☐Yes ☐No

SECTION VI: ANTICIPATED DISCHARGE NEEDS

(Must be completed if requesting Inpatient Admission / Procedure)

☐DME - list specific items / codes

☐Home Health - list specific services along with duration / frequency

☐Inpatient Acute Rehab ☐Skilled Nursing Facility

Please fax back to HVHS at 1-866-836-4991