

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				
<input type="checkbox"/> Radiology / Imaging : CPT code _____		<input type="checkbox"/> Inpatient Admission: <input type="checkbox"/> Acute Care <input type="checkbox"/> Rehab <input type="checkbox"/> SNF		
<input type="checkbox"/> In-Office Procedure: CPT code(s) _____		<input type="checkbox"/> Labs		
<input type="checkbox"/> Surgical / Diagnostic Procedure: CPT code _____		<input type="checkbox"/> Speech Therapy		
<input type="checkbox"/> Inpatient (must complete section VI) <input type="checkbox"/> Outpatient		<input type="checkbox"/> PT / OT		
<input type="checkbox"/> Additional Office Visits (listed # needed)		<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No				
SECTION VI: ANTICIPATED DISCHARGE NEEDS				
(Must be completed if requesting Inpatient Admission / Procedure)				
<input type="checkbox"/> DME - list specific items / codes				
<input type="checkbox"/> Home Health - list specific services along with duration / frequency				
<input type="checkbox"/> Inpatient Acute Rehab <input type="checkbox"/> Skilled Nursing Facility				

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