



VA ER/OBSERVATION ALERT

(VA ER FAX: 1-907-770-2077)

TODAY'S DATE: _____

HOSPITAL NAME: _____ HOSPITAL FAX: _____

ER PHYSICIAN: _____ PHYSICIAN'S PHONE: _____

DATE OF SERVICE: _____

VETERAN'S NAME: _____ SSN: _____

DIAGNOSIS: _____

SPECIALTY: MED _____ SURG _____ PSYCH _____ REHAB _____ SUB ABUSE _____

ADDITIONAL INSURANCE INFORMATION: _____

***** VETERAN'S STATEMENT: I request VA coverage for this episode of care. In accordance with the law, I understand I am subject to transfer to a federal facility.**

Signature of veteran or family member: _____

(Please, do not write below this line, for VA use only)

AUTHORIZED: _____ **NOT AUTHORIZED:** _____

REPORT OF CONTACT IN SYSTEM: _____ DENIAL LETTER SENT: _____

FORMS NEEDED TO BE COMPLETED: 1010 _____ 1010F/EZ _____ DD214 _____

VETERAN ELIGIBILITY: Seen for SC Condition? _____ NSC Condition? _____

VETERAN ENROLLED? _____ 10-583(a) Completed? _____

VETERAN TREATED AT VA FACILITY IN PAST 24 MONTHS? _____