



# ALASKA VA OUTPATIENT AUTHORIZATION REQUEST

Phone: 257-6904 or 1-888-353-7574 ext. 6904

**\*\*\*NOTES MUST ACCOMPANY THIS REQUEST\*\*\***

Fax: 907-770-2077

(Anchorage, Glennallen, Seward, Kenai, Soldotna, and Homer AK)

Today's Date: \_\_\_\_\_

Vendor's Name: \_\_\_\_\_

Vendor's Address: \_\_\_\_\_

Vendor's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Tax Id: \_\_\_\_\_

Veteran's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Desired treatment, procedure, or referral: \_\_\_\_\_

Lab \_\_\_\_\_ X-ray \_\_\_\_\_ Rx \_\_\_\_\_ Other \_\_\_\_\_

Date of desired treatment, procedure, or referral: \_\_\_\_\_

Location of treatment if different from doctor's office: \_\_\_\_\_

Period of Care: Yes \_\_\_\_\_ No \_\_\_\_\_ (Indicate length of time and number of visits)

Surgical Procedure: Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, list CPT codes with cost estimates & ancillaries)

Comments: \_\_\_\_\_