VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

NNPO Non-VA Medical Care Coordination

Authorization Fact Sheet for Pre-authorized Care

VA Form 10-7078/10-7079

Fact sheet purpose

The National Non-VA Medical Care Program Office (NNPO) provides the following guidance regarding the quality of information contained within an authorization–VA Forms 10-7078 and 10-7079 – and standardizing authorization correspondence across Veterans Health Administration (VHA) facilities. NNPO, in conjunction with the Non-VA Care Coordination Team under the Chief Business Office (CBO), promotes Non-VA Care Coordination (NVCC) standardized processes.

What is an authorization?

An authorization for care is the cornerstone for delivering purchased care and the blueprint for paying a claim properly. An authorization gives the non-VA provider authority to provide health care to the Veteran patient, and provides assurance of payment for those services. The authorization document binds VA to the language that is included on the authorization.

How is an authorization established?

Once a non-VA care consult is submitted, it must be reviewed and approved both administratively and clinically. Administrative approval indicates the patient is eligible for a VHA medical benefits package and care outside the VA, if required. Clinical approval indicates the care is medically necessary for the patient's health and well-being per NVCC processes. After establishing administrative and clinical approval, the facility's Non-VA Care Team will generate an authorization for care. The legal document outlining outpatient care to be received is the VA Form 10-7079; inpatient care is authorized using VA Form 10-7078. These forms may be generated using the Fee Basis Claims System (FBCS) authorization module, the VistA Authorization Entry menu or equivalent.

A completed authorization is sent to the Veteran along with the standardized Non-VA Care Patient Letter located in Computerized Patient Record System (CPRS). The Non-VA Provider Authorization Letter is sent with a copy of the authorization that contains detailed information regarding the services authorized, episode of care (EOC) time frame, Electronic Data Interchange (EDI) claim payment information, instructions for return of clinical documentation, prescriptive guidance and Durable Medical Equipment (DME) information. NNPO requires that this correspondence is sent to the non-VA provider with each authorization. The above aligns with Non-VA Care Coordination Referral Review and Appointment Management Processes.

For more detailed information regarding Non-VA Care Coordination Referral Review and Appointment Management processes, please go to the SOP's/Process Guides section on the NVCC intranet site at *http://nonvacare.hac.med.va.gov/nvcc/sop-and-guides.asp*

Negotiated agreements may only be undertaken for pre-authorized non-VA care under 38 U.S.C. §1703. Negotiated agreements must be documented in writing on VA Forms 10-7078, 10-7079, or 10-2570D (dental authorization), as applicable, and issued with the standardized NNPO Non-VA Provider Authorization Letter to the non-VA provider prior to the rendering of services.

The policy for negotiated agreements may be found on the NNPO website under the Procedure Guide section: *"Using VA Forms as Negotiated Agreements for Non-VA Preauthorized Health Care Services"* at *http://nonvacare.hac.med.va.gov/policy-programs/procedure-guides.asp*

The NNPO Non-VA Provider Authorization Letter can be found on the NNPO website at *http://nonvacare.hac.med.va.gov/policy-programs/tools.asp* and on the NVCC website at *http://nonvacare.hac.med.va.gov/nvcc/templates.asp*

What are the benefits of a CLEAR and CONCISE authorization?

- Decrease the number of incorrectly denied claims
- Decrease facility liability for services provided beyond what was approved by VA
- Reduce vulnerability of financial claims against the VA
- Reduce the risks of "surprise" charges
  ~ If the intent of the EOC is clearly stated, and if allowable or non-allowable procedures are listed, it is less likely that the provider will perform services that will not be reimbursed by VA.
- Allow for improved financial planning
  ~ Support more realistic cost estimation for obligated funds

  ~ Allow facilities to retain some control over what services are performed
- Avoid misunderstanding between the VA and non-VA providers
  ~ Clear and concise authorizations can assist in creating a stronger partnership between VA and non-VA resources which, in turn, benefits our Veteran patients

Authorization requirements

1. **Standard language:** Authorizations MUST begin with the following statement and should clearly inform the provider that VA payment is considered payment in full:

   "Upon acceptance of this authorization the provider agrees to accept VA payment as payment in full for the services described herein."

   Also, per negotiated agreement, this should be the ending statement of each authorization:

   "By Federal regulation VA is the primary and exclusive payer for medical care it authorizes. As such, you may not bill the Veteran or any other party for any portion of the care authorized by VA. Federal law also prohibits payment by more than one Federal agency for the same episode of care; subsequently any payments made by Medicare or any other Federal agency must be refunded to the payer by your facility."

TIP: Edit VA Forms 10-7078/10-7079 in FBCS to include the above statements. FBCS contains boiler plate templates which may be used to auto populate the opening and closing statements in the authorization.

2. **Additional requirements:** Each authorization must also include the following information:
   - Identify "Inpatient" or "Outpatient" on the authorization
   - List the specific services authorized. Provide details, including CPT and HCPCS codes, if possible.
   - Cost estimation is required for services authorized. Cost estimation links are located at *http://nonvacare.hac.med.va.gov/policy-programs/cost-estimation-outpatient.asp* (Outpatient) and *http://nonvacare.hac.med.va.gov/policy-programs/cost-estimation-inpatient.asp* (Inpatient)
   - Identify any services which will NOT be covered/paid under non-VA care/purchased care auspices:
     ~ Include a statement to communicate if specific services associated with the EOC are to be provided by the VA (e.g., lab tests, radiology studies, etc.).

     Example: "All pre-operative labs will be obtained at the VA facility, not by a non-VA provider/facility."

     - Refer to the Accounting of Disclosure (pg. 24, para. 9) and the ROI (Release of Information) Policy (pg. 37-41): *http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1423*
   - Medical devices or appliance
     ~ Prosthetic items are strictly issued by the VA prosthetics department. The list of items should be submitted to the VA in order for prosthetics to dispense the items. If a prescription for a medical device or appliance is provided, the non-VA provider will be asked to contact the local VA prosthetic department by phone as all medical devices and appliances will be ordered and supplied by VA staff for the determined eligible Veteran. This information is communicated to the VA patient per the required NNPO Non-VA Care Patient Appointment Letter (sent to the patient with a copy of the authorization) and the non-VA provider per the required NNPO Non-VA Provider Authorization Letter (sent to the non-VA provider with a copy of the authorization).
   - Prescriptions
     ~ Prescriptions may only be filled by a non-VA pharmacy when the medication is needed

promptly to treat an emergent or urgent medical condition; in such instances, the Veteran may use a local pharmacy to obtain up to a 10-day supply of medication. VA will not reimburse for any medication that is not on the VA National Formulary listing: *http://www.pbm.va.gov/NationalFormulary.asp*

NOTE: Non-VA providers should write two prescriptions for urgently needed medications; one for a 10-day supply to be filled at a local pharmacy, and one to be filled at the VA pharmacy.

~ Prescriptive authority (Non-VA Medical Care – formerly Fee Basis): Once a patient provides a non-VA care prescription associated with the authorized EOC, a pharmacy is required to follow the fee basis policy in VHA Handbook 1108.05, *Outpatient Pharmacy Services*, section 8; para. 5 at *http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=1431*

- Number of visits authorized
  Example: One initial consult/evaluation and two follow up visits for a total of three visits.
- Frequency of visits:
  Example: Two visits per week for two weeks.
- Period of validity: "From – To Dates" for authorized services
  Example: Authorization valid 12/01/11 – 02/01/12
- Provide VA contact information. Include if additional services or visits are indicated.
  Example: "If additional services and/or visits are required, please contact the VA at <number> as prior authorization is required."

3. **Payment methodology:** An authorization will clearly state the payment methodology used for reimbursement. Authorizations that have no reference to any payment methodology leave the VA open to interpretation as to the payment amount for the service.
   - When there is no contract or negotiated agreement in place with the non-VA provider, VA will pay claims in accordance with established regulations under 38 CFR 17.55, 17.56.
   - VA payment methodology is specific to the type of care rendered (Inpatient and Outpatient). Please refer to the NNPO Fee Payment Chart released in January 2012. It can be found on the NNPO website at *http://nonvacare.hac.med.va.gov/policy-programs/tools.asp*
   - If the services provided are part of a contractual agreement, the author may include a statement such as: "Reimbursement will be <payment methodology here>." Rates or percentages as they appear in the contract language may be included.
   - In the absence of a Medicare rate, contract or negotiated agreement, payment will be made under the 75th percentile methodology (local fee schedule) which is determined for each VA medical facility by ranking all occurrences (with a minimum of eight) under the corresponding code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid.
   - Claims may be submitted to a contracted repricing agency, if applicable, prior to claims processing.

Reference links

The following links provide additional resources and information regarding the appropriate use of authorization notifications for non-VA care:

- National Non-VA Medical Care Program Office (NNPO) intranet site – *http://nonvacare.hac.med.va.gov/*
- Non-VA Care Coordination (NVCC) intranet site – *http://nonvacare.hac.med.va.gov/nvcc/*
- NNPO Cost Estimation Tool (Outpatient) intranet site – *http://nonvacare.hac.med.va.gov/policy-programs/cost-estimation-outpatient.asp*
- NNPO Cost Estimation Tool (Inpatient) intranet site – *http://nonvacare.hac.med.va.gov/policy-programs/cost-estimation-inpatient.asp*
- NNPO Fee Payment Chart intranet site – *http://nonvacare.hac.med.va.gov/docs/tools/FeePaymentChart.xlsx*
- NNPO Negotiated Agreements intranet site – *http://nonvacare.hac.med.va.gov/policy-programs/procedure-guides.asp*
- Episode of Care (EOC) intranet site – *http://nonvacare.hac.med.va.gov/policy-programs/fact-sheets.asp*
- Accounting of Disclosure (AOD); (pg. 31, para. 9) – *http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1423*
- ROI (Release of Information) – *http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1423*
- Fee Basis Pharmacy Services – Prescriptive Authority (section 8; para. 5) – *http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=1431*

Sample Authorization Notification Form

VA Department of Veterans Affairs	VA Form 10-7078

AUTHORIZATION AND INVOICE FOR MEDICAL AND INPATIENT HOSPITAL SERVICES

Issuing Office:	Date of Issue:	Type of Service:
VA Medical Center Station XXX Street Name, City, State, Zip Telephone (XXX-XXX-XXXX) Fax (XXX-XXX-XXXX)	Feb. 02, 2010 Veteran's Name: John Doe	(List Inpatient or Other, if Other - describe)

Name of Physician or Station:	Veteran's Address:
Newark Wayne Community Hospital PO BOX 111 Newark, NY 14513-1057 ID#: 15058418802	790 E. Maple Ave., Newark, NY 14513 Veteran's Claim #: SSN XXXX

Name of VA Referring Provider:		Authorization Period of Validity	
	NPI:	From:	To:
		Feb. 02, 2012	May 02, 2012

SERVICES AUTHORIZED

If additional services or extended stay is required, you must notify the Non-VA Medical Care Office.

Type of Care: (Mark One)	Authorized by:
____ Non-VA Medical Care ____ Contract ____ MOU	Name and Title

List of Services Authorized per the Period of Validity:		Cost Estimation:
1.	2.	$
3.	4.	

AUTHORIZATION COMMENTS / EXCEPTIONS

Total Number of Visits Authorized:	Frequency of Visits:
Example: 1 (One) Inpatient Stay	*Example:* 1 (One)

PAYMENT METHODOLOGY

Upon acceptance of this authorization the provider agrees to accept VA payment as payment in full for the services described herein. As such, you may not bill the Veteran or any other entity for any portion of the care authorized by VA.

This is authorization to provide hospital and associated professional services to the veteran referenced above, for the purpose of <DIAGNOSIS>. The VA will be responsible for this inpatient treatment through the point at which the medical emergency ends and the patient may be discharged or safely transferred to a VA facility for continuation of care.

VA FORM FEB 2013 **10-7078**

Services are hereby authorized by VA under the provisions of 38 U.S.C. 1703. Payment will be rendered in accordance with the statute and federal regulation 38 CFR U.S.C. 17.55, 17.56. When there is no contract or negotiated agreement in place with the non-VA provider, VA will pay claims in accordance with established regulations.

Inpatient service payments per: IPPS, CTC ratio, Maryland waiver and paid in accordance with the terms outlined in the waiver. Reimbursement will be: Appropriate <contracted rate; or non-VA DRG PRICER based rate; or negotiated agreement rate; or payment methodology> as outlined under 38 U.S.C. 1703, or 38 U.S.C. 1728 or 38 U.S.C. 1725 or Cost-to-Charge Ratio. If services are rendered in a Critical Access Hospital, VA will not pay as Medicare. You may not bill the Veteran, or their insurance (including Medicare) for any balance remaining.

CONTRACTED SERVICES / MOU: If the services provided are part of a contractual agreement, reimbursement will be per the terms of the contract or negotiated agreement. The Veteran shall not pay any provider of medical services any portion of the bills for this treatment. You may not bill the Veteran, or their insurance (including Medicare) for any balance remaining. Rates or percentages as they appear in the contract language may be included. When a specific non-VA provider has a written contract, negotiated agreement, or memorandum of agreement with VA for a specific service, VA payment will be computed at the rate specified in the contract or agreement.

PRESCRIPTIONS: Medication(s) prescribed for routine care by a non-VA provider, and in conjunction with this authorization, must be submitted and ordered by a VA provider and filled at a VA pharmacy. An approved list of formulary VA medications can be found on the VA National Formulary listing at *http://www.pbm.va.gov/NationalFormulary.asp*

Prescriptions may only be filled by a non-VA pharmacy when the medication is needed promptly to treat an emergent or urgent medical condition; in such instance, the Veteran may use a community pharmacy to obtain up to a 10- day supply of medication. VA will not reimburse for any medication that is not on the VA National Formulary listing.

NOTE: Non-VA providers should write two prescriptions; for urgently needed medications, one for the 10-day supply to be filled at the local pharmacy, and a second prescription for the VA pharmacy.

If a prescription for a medical device or appliance is provided, please contact the VA Prosthetic Department at <telephone number>, as all medical devices and appliances will be ordered and supplied by VA staff for the determined eligible Veteran.

Daily or every other day progress notes must be faxed to <telephone #> for inclusion on the Veteran's Consolidated Health Record. Discharge planning should be a joint effort between the treating facility and the VA Medical Center. Requests for DME, follow up care, continued inpatient care, inpatient rehabilitation, etc., must be coordinated with the patient's Primary Care physician through the Non-VA Care Program Office. The only exception to this is if the patient intends to pay for such after care via private means and not the VA. Please plan for discharge needs as far in advance as possible in order to allow time to process requests through the VA system.

Discharge planning must be coordinated with the VA in order to avoid unnecessary delays to the delivery of patient care.

- Post discharge medication needs: Prescriptions may be submitted to the VA Pharmacy by contacting <telephone #>.
- Post operative DME/Prosthetic needs: The list of these items must be submitted to the VA in order to be dispensed by the VA prosthetics department.
- Recommendations for post-surgical therapies. Please indicate if the patient will require outpatient Physical Therapy, Home Physical Therapy, placement in a Rehab facility setting, Home Health nursing, etc.
- Post discharge outpatient appointments must be coordinated with the VA. Any outpatient follow up outside the VA requires separate approval and authorization by the responsible VA.

FILING A CLAIM: Please return the original Department of Veterans Affairs Form 10-7078 (which will be mailed upon patient's discharge), along with your UB-92 Form or CMS 1450, an itemized statement, and complete copies of the hospital medical records, to include hospital emergency room notes, ER report, ambulance report and diagnostic study results within 30 calendar days of discharge to <Facility Address>

To prevent cancellation of the funds set aside for this authorization, ALL documentation requested must be received within 60 days of the date of this correspondence.

>>Please notify all ancillary providers and their billing services of this deadline<<!

**To facilitate an expedited payment please submit using Electronic Data Interchange (EDI) with VA Payer: ID # 12115 under the Name: VA Fee Basis Programs. The following forms will be accepted: CMS 1500, CMS 1450, and ADA J400. Please use the following link: *http://www.Emdeon.com*

**If you must use paper claims please submit on the appropriate red and white form to the following address:
<Facility Address>

MEDICAL RECORDS: Must be submitted with the claims via electronic (EDI) or paper. All claims may be submitted to a contracted repricing agency if applicable prior to claims processing. Any questions regarding this authorization may be directed to: <VA Point of Contact – Telephone Number>. Upon receipt of the aforementioned information, your claim will be processed for payment in accordance with VA directives.

*If the patient indicates a preference to have this period of hospitalization filed under private insurance or Medicare, please notify this office immediately.

By Federal regulation VA is the primary and exclusive payer for medical care it authorizes. As such, you may not bill the Veteran or any other party for any portion of the care authorized by VA. Federal law also prohibits payment by more than one Federal agency for the same episode of care; subsequently any payments made by Medicare or any other Federal agency must be refunded to the payer by your facility. Acceptance of this authorization is to accept VA payment as payment in full for the services described herein.

ALL QUESTIONS RELATED TO THIS AUTHORIZATION SHOULD BE REFERRED TO THE ISSUING VA OFFICE:

<VA POC Name>
<Telephone Number>

VA FORM FEB 2013 **10-7078**

Sample VA Form 10-1079

VA Department of Veterans Affairs	VA Form 10-7079	ID Card Number:

REQUEST FOR OUTPATIENT SERVICES

Veteran Name:	ID Number:	Address:
John Doe		

Veteran's Claim #:	SSN (Last 4):	DOB (Day/Month/Year):
	XXXX	XX/XX/XXXX

Issuing Office:	Name of VA Referring Provider:	NPI:
VA Medical Center Station XXX Street Name, City, State, Zip Telephone (XXX-XXX-XXXX) Fax (XXX-XXX-XXXX)		Authorization Number:

Date of Issue:	Conditions for Which Services are Requested:
Feb. 02, 2010	Provide Description of Condition/Disability

State Code:	County Code:	Type of Patient:	Year of Birth:	War:	Purpose:	Sex (M/F):	POW (Y/N):	Code:

AUTHORIZATION REMARKS

Type of Care (Mark One):	Authorization Period of Validity	
	From:	To:
____ Non-VA Medical Care ____ Contract ____ MOU	Feb. 02, 2012	May 02, 2012

Station of Jurisdiction:	Approved By:
VA Medical Center Station XXX Street Name, City, State, Zip Telephone (XXX-XXX-XXXX) Fax (XXX-XXX-XXXX)	Name and Title VA Medical Center Chief of Staff or Delegated POC

SERVICES AUTHORIZED	Cost Estimate/Fee
The patient is authorized for initial evaluation not to exceed < $ > for the purpose of determining need and suitability of <diagnosis/procedure>. If additional services are required or the patient requires hospitalization, you must notify the Non-VA Care Program Office as these services would not be covered under this Authorization.	$
Authorized By:	
Name and Title	

List of Services Authorized per the Period of Validity:	
1.	2.
3.	4.

List of Services **NOT** Authorized:	
1.	2.
3.	4.

Total Number of Visits Authorized:	Frequency of Visits:
Example: 1 Consult, 2 Follow up visits	*Example:* 2x / month

PAYMENT METHODOLOGY

Upon acceptance of this authorization the provider agrees to accept VA payment as payment in full for the services described herein. As such, you may not bill the Veteran or any other entity for any portion of the care authorized by VA. This is authorization to provide outpatient hospital and professional outpatient medical services to the Veteran referenced above, for the purpose of <DIAGNOSIS>. The VA will be responsible for this episode of care as referenced in this authorization.

Services are hereby authorized by VA under the provisions of 38 U.S.C. 1703. Payment will be rendered in accordance with this statute and federal regulation 38 CFR U.S.C. 17.55, 17.56. When there is no contract or negotiated agreement in place with the non-VA provider, VA will pay claims in accordance with established regulations.

Reimbursement will be: Appropriate <contracted rate; or Negotiated agreement rate; or payment methodology> as outlined under 38 U.S.C. 1703 or 38 U.S.C. 1728 or 38 U.S.C. 1725 or the local Fee Schedule. You may not bill the Veteran or their insurance (Including Medicare) for any balance remaining.

CONTRACTED SERVICES/MOU: If the services provided are part of a contractual agreement, reimbursement will be per the terms of the contract or negotiated agreement. The Veteran shall not pay any provider of medical services any portion of the bills for this treatment. You may not bill the Veteran, or their insurance (including Medicare) for any balance remaining. Rates or percentages as they appear in the contract language may be included. When a specific non-VA provider has a written contract, negotiated agreement, or memorandum of agreement with VA for a specific service, VA payment will be computed at the rate specified in the contract or agreement.

INITIAL EVALUATION visit not to exceed < $ >. Upon completion of evaluation, initial findings and plan of care should be submitted to the referring facility. Unexpected or unanticipated outcomes must be communicated directly to the patient at the time of the visit and communicated to the referring provider within 24 hours. Treatment notes must be submitted to the referring facility as soon as possible.

<Preliminary lab findings and radiology reports have been performed at the referring VA and are attached. > (OR) <SEE AUTHORIZATION FOR DIAGNOSTICS BELOW>

ANY SAME DAY, IN-OFFICE PROCEDURES/DIAGNOSTICS REQUIRED FOR EVALUATION OR AUTHORIZED TREATMENT. These procedures may include routine diagnostic testing such as labs, x-rays, ultrasounds, or CT Scan. In the event procedures or diagnostics are to be referred to a secondary agency, prior authorization should be obtained by contacting <telephone number>. If inpatient admission is indicated, the referring VA facility must be notified immediately, as inpatient admission and care requires separate authorization.

IF SURGERY IS REQUIRED: Notification must be made prior to the surgery as to the scheduled date and time. If inpatient surgery is indicated, it is imperative to notify the referring facility prior to the surgery date and immediately upon admission (inpatient care requires a separate authorization, and case management by VA nursing staff). The treating provider must submit the following items to the referring facility at least 10 working days prior to the admission date for scheduled surgery:

- Post operative medication needs: Prescriptions may be submitted to the VA pharmacy by contacting <telephone #>.
- Post operative DME/prosthetic needs: The list of these items must be submitted to the VA in order to be dispensed by VA Prosthetics Department.
- Recommendations for post-surgical therapies. Please indicate if the patient will require outpatient Physical Therapy, Home Physical Therapy, placement in a Rehab facility setting, Home Health nursing, etc. Discharge medications.
- These items must be in place prior to admission in order to facilitate discharge planning and avoid unnecessary delays to delivery of patient care.

ANY ADDITIONAL SERVICES (NOT PERFORMED IN-OFFICE) REQUIRE PRIOR APPROVAL. No other surgeries/studies/procedures or admissions are to be performed without prior authorization from the referring agency. Please contact <telephone number> for all prior authorization. In the event emergent admission is required, contact <telephone number> for guidance.

PRESCRIPTIONS: The evaluating/treating physician may make medication recommendations and provide the patient with a prescription. Prescriptions must be submitted to the VA for dispensing. Prescriptions should adhere to the national VA Formulary. Questions regarding prescriptions or formulary may be directed to the patient's primary care provider or the VA pharmacy at <telephone number>. An approved list of formulary VA medications can be found on the VA National Formulary listing at *http://www.pbm.va.gov/NationalFormulary.asp*

PROSTHETICS / DME GUIDANCE: Prosthetic items are strictly issued by the VA Prosthetics Department. A list of necessary items must be submitted to the VA in order to allow time for dispensing of items by the VA Prosthetics Department. If a prescription for a medical device or appliance is provided, please contact the VA Prosthetics Department at <telephone number>, as all medical devices and appliances will be ordered and supplied by VA staff for the determined eligible Veteran.

FILING A CLAIM: To prevent cancellation of the funds set aside for this authorization, ALL documentation requested MUST be received within 60 days of the date of this correspondence

>>Please notify all ancillary providers and their billing services of this deadline<<!

**To facilitate an expedited payment, please submit using Electronic Data Interchange (EDI) with VA Payer: ID # 12115 under the Name: VA Fee Basis Programs. The following forms will be accepted: CMS 1500, CMS 1450, and ADA J400. Please use the following link: *http://www.Emdeon.com*

**If you must use paper claims please submit on the appropriate red and white form to the following address:
<Facility Address>

MEDICAL RECORDS: Must be submitted with the claims via electronic (EDI) or paper. All claims may be submitted to a contracted repricing agency if applicable prior to claims processing. Any questions regarding this authorization may be directed to: <VA Point of Contact – Telephone Number>

Upon receipt of the aforementioned information, your claim will be processed for payment in accordance with VA directives.

*If the patient indicates a preference to have this episode of care filed under private insurance or Medicare, please notify this office immediately.

By Federal regulation VA is the primary and exclusive payer for medical care it authorizes. As such, you may not bill the Veteran or any other party for any portion of the care authorized by VA. Federal law also prohibits payment by more than one Federal agency for the same episode of care; subsequently any payments made by Medicare or any other federal agency must be refunded to the payer by your facility. Acceptance of this authorization is to accept VA payment as payment in full for the services described herein.

ALL QUESTIONS RELATED TO THIS AUTHORIZATION SHOULD BE REFERRED TO THE ISSUING VA OFFICE:

<VA POC Name>
<Telephone Number>