Department of Veterans Affairs

AUTHORITY FOR ISSUANCE OF SPECIAL AND/OR EXPERIMENTAL APPLIANCES

INSTRUCTIONS: Prepare this form, save a copy and e-mail a copy to (10FP).

SECTION I - *(To be completed by station)*

TO	VHA Chief Prosthetics and Clinical Logistics Office (10FP) Department of Veterans Affairs Central Office Washington, D.C. 20420	VETERAN'S NAME *(Last, First, Middle)*		VETERAN'S ADDRESS
		LAST 4 DIGITS OF SSN	DATE OF REQUEST	VETERAN'S STATUS AND ELIGIBILITY ☐ SC ☐ NSC

SPECIFIC DISABILITY REQUIRING SPECIAL ITEM AND ICD 9 CODE

FULL DESCRIPTION OF ITEM REQUESTED *(Attach descriptive literature if available. ATTACHMENTS WILL NOT BE RETURNED.)*

ITEM NAME	WEBSITE
MAKE	VENDOR
MANUFACTURER	COST
FDA APPROVED ☐ YES ☐ NO	

FULL MEDICAL JUSTIFICATION FOR SPECIAL ITEM *(Use reverse or attach additional sheets if necessary. ATTACHMENTS WILL NOT BE RETURNED.)*

NAME, TITLE, AND MEDICAL SPECIALTY OF PRESCRIBING PHYSICIAN	CERTIFICATION: I certify that the requested item has been prescribed as medically necessary for treatment of the prosthetics disability listed, and that funds for procurement are available.
NAME AND LOCATION OF REQUESTING STATION	SIGNATURE OF PROSTHETICS CHIEF

SECTION II- *(To be completed by Central Office)*

DATE RECEIVED	ACTION	DATE OF ACTION
	☐ APPROVED ☐ DISAPPROVED ☐ DEFERRED PENDING FURTHER JUSTIFICATION	

CONCURRENCES		REMARKS AND/OR INSTRUCTIONS/ REASON FOR DISAPPROVAL
SYMBOL	INITIALS	

SIGNATURE AND TITLE

SECTION III- *(To be completed by Prosthetics Chief)*

IF APPROVED:	VENDOR
HCPCS	COST
NATIONAL ITEM FILE NUMBER	DATE PURCHASED