



PREVIOUS AUTHORIZATION NUMBER:

TODAY'S DATE (MM/DD/YYYY):

NOTE: The Request for Services (RFS) Form 10-10172 must be submitted via an approved method (HSRM, Electronic Fax, Direct Messaging, Traditional Fax, or Mail) to your local VA community care office. Completion of this form is REQUIRED and MUST BE SIGNED by the requesting provider for further care to be rendered to a Veteran patient.

SECTION I: VETERAN INFORMATION

1. VETERAN'S LEGAL FULL NAME (First, MI, Last):		2. DOB (MM/DD/YYYY):
3. VA FACILITY:	4. VA LOCATION:	

SECTION II: ORDERING PROVIDER INFORMATION

5. REQUESTING PROVIDER'S NAME:	6. NPI #:	7. SPECIALTY:
8. OFFICE NAME & ADDRESS:		
9. SECURE EMAIL ADDRESS:		
10. PHONE NUMBER:	11. FAX NUMBER:	<input type="checkbox"/> 12. INDIAN HEALTH SERVICES (IHS) PROVIDER?

SECTION III: TYPE OF CARE REQUEST

13. PLEASE INDICATE CLINICAL URGENCY (Urgent care is only applicable for requests that require less than 3 days to process. If care is needed within 48 hours or if Veteran is at risk for Suicide/Homicide, please call the VA directly on the same day as completed RFS form submission. Do NOT mark urgent for administrative urgency):
 ROUTINE URGENT

14. DIAGNOSIS (ICD-10 Code/Description):	15. DATE OF SERVICE (MM/DD/YYYY) &/OR ANTICIPATED LENGTH OF CARE:
16. CPT/HCPCS CODE &/OR DESCRIPTION OF REQUESTED SERVICES (Include units/visits, add second list page, if needed):	

17. HOW MANY VISITS HAVE OCCURRED SO FAR? (If known)	18. IS THIS A REFERRAL TO ANOTHER SPECIALTY? <input type="checkbox"/> YES (If "YES," please fill out the Servicing Provider/Specialty information below) <input type="checkbox"/> NO	
19. SERVICING PROVIDER'S NAME:	20. NPI #:	21. SPECIALTY:
22. OFFICE NAME & ADDRESS:		
23. SECURE EMAIL ADDRESS:		
24. PHONE NUMBER:	25. FAX NUMBER:	

SECTION IV: TYPE OF SERVICE REQUESTED

26. OUTPATIENT CARE: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SPEECH THERAPY	27. SURGICAL PROCEDURE: <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT
FREQUENCY & DURATION:	FACILITY NAME:
28. <input type="checkbox"/> IN-OFFICE PROCEDURE	29. INPATIENT CARE: <input type="checkbox"/> LTACH <input type="checkbox"/> ACUTE REHAB <input type="checkbox"/> BH
30. <input type="checkbox"/> ADDITIONAL OFFICE VISITS (List # needed):	31. <input type="checkbox"/> EXTENSION OF VALIDITY DATES
32. <input type="checkbox"/> EMERGENCY ROOM CARE	33. <input type="checkbox"/> LABS (If done outside of office, please provide facility name above in box #27)
34. <input type="checkbox"/> RADIOLOGY/IMAGING (If done outside of office, please provide facility name above in box #27)	35. <input type="checkbox"/> PRE-OP LABS <input type="checkbox"/> CHEST XRAY <input type="checkbox"/> EKG <input type="checkbox"/> OTHER:

36. JUSTIFICATION FOR REQUEST (To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results &/or medications to support the medical necessity of services requested).

VETERAN'S LEGAL FULL NAME (<i>First, MI, Last</i>):	
SECTION IX: THERAPEUTIC FOOTWEAR ASSESSMENT INFORMATION (<i>If applicable</i>)	
<p>54. FILL OUT THE INFORMATION BELOW (<i>If applicable</i>):</p> <p><input type="checkbox"/> LEFT FOOT <input type="checkbox"/> RIGHT FOOT <input type="checkbox"/> BILATERAL</p> <p><input type="checkbox"/> PREFABRICATED THERAPEUTIC FOOTWEAR</p> <p><input type="checkbox"/> CUSTOM THERAPEUTIC FOOTWEAR</p>	<p>NOTE: For prescription of therapeutic footwear due to disease pathology resulting in neuropathy or peripheral artery disease.</p>
<p>NOTE: For prescription of therapeutic footwear for severe or gross foot deformity which cannot be accommodated with conventional footwear.</p> <p>DESCRIBE FOOT DEFORMITY AND ADDITIONAL DETAILS:</p>	<p>55. CHECK APPROPRIATE DIABETIC/AMPUTATION RISK SCORE:</p> <p><input type="checkbox"/> RISK SCORE 2: PATIENT DEMONSTRATED SENSORY LOSS (<i>inability to perceive the Semmes-Weinstein 5.07 monofilament</i>), DIMINISHED CIRCULATION AS EVIDENCED BY ABSENT OR WEAKLY PALPABLE PULSES, FOOT DEFORMITY, OR MINOR FOOT INFECTION, & A DIAGNOSIS OF DIABETES.</p> <p><input type="checkbox"/> RISK SCORE 3: PATIENT DEMONSTRATED PERIPHERAL NEUROPATHY WITH SENSORY LOSS (<i>i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament</i>), AND DIMINISHED CIRCULATION, AND FOOT DEFORMITY, OR MINOR FOOT INFECTION & A DIAGNOSIS OF DIABETES, OR ANY OF THE FOLLOWING BY ITSELF: (1) PRIOR ULCER, OSTEOMYELITIS OR HISTORY OF PRIOR AMPUTATION; (2) SEVERE PERIPHERAL VASCULAR DISEASE (<i>PVD</i>) (<i>intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration or gangrene</i>); (3) CHARCOT'S JOINT DISEASE WITH FOOT DEFORMITY; & (4) END STAGE RENAL DISEASE.</p> <p>NOTE: Only patients who are experiencing medical conditions noted in the risk scores can be prescribed therapeutic/diabetic footwear.</p>
<p>*ATTESTATION: I do hereby attest that the forgoing information is true, accurate, & complete to the best of my knowledge & I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. I do hereby acknowledge that VA reserves the right to perform the requested service(s) if the following criteria are met: (1) The patient agrees to receive services from VA (2) Service(s) are available at VA facility & are able to be provided by the clinically indicated date (3) It is determined to be within the patient's best interest. Upon completion of the requested service(s), VA will provide all resulting medical documentation to the ordering provider. If all criteria listed are not true & VA agrees the service(s) are clinically indicated, VA will provide a referral for services to be performed in the community. I do hereby attest that upon receipt of order/consult results, I will assume responsibility for reviewing said results, addressing significant findings, & providing continued care.</p>	
56. REQUESTING PROVIDER SIGNATURE (<i>Required</i>):	57. TODAY'S DATE (<i>MM/DD/YYYY</i>):

To facilitate timely review of this request, the most recent office notes & plan of care must accompany this signed form.

For more information please visit: <https://www.va.gov/COMMUNITYCARE/providers/Care-Coordination.asp>.

For additional contact information, please visit: <https://www.va.gov/COMMUNITYCARE/providers/Care-Coordination-Facilities.asp>.

Additional Resource: Clinical Determinations and Indications

VA Clinical Determinations and Indications (medical policies) describe standard VA health care benefits for services and procedures that community providers may recommend as necessary for a Veteran. Prior to providing care, providers should use Clinical Determinations and Indications (CDIs) as a reference when determining if a Veteran meets VA clinical criteria. When additional services are requested, Clinical Determinations and Indications will be used to determine approval by a clinical reviewer.

Clinical Determinations and Indications, as well as supporting information, can be found at:

<https://www.va.gov/COMMUNITYCARE/providers/Medical-Policy.asp>