Department of Veterans Affairs

REQUEST FOR SERVICES (RFS) FORM

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:	☐ 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? ☐ YES *(If "YES," please fill out the Servicing Provider/Specialty information below)* ☐ 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: ☐ PT ☐ OT ☐ SPEECH THERAPY FREQUENCY & DURATION:	27. SURGICAL PROCEDURE: ☐ INPATIENT ☐ OUTPATIENT FACILITY NAME:
28. ☐ IN-OFFICE PROCEDURE	29. INPATIENT CARE: ☐ LTACH ☐ ACUTE REHAB ☐ BH
30. ☐ ADDITIONAL OFFICE VISITS *(List # needed)*:	31. ☐ EXTENSION OF VALIDITY DATES
32. ☐ EMERGENCY ROOM CARE	33. ☐ LABS *(If done outside of office, please provide facility name above in box #27)*
34. ☐ RADIOLOGY/IMAGING *(If done outside of office, please provide facility name above in box #27)*	35. ☐ PRE-OP LABS ☐ CHEST XRAY ☐ EKG ☐ 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 *(First, MI, Last)*:

SECTION V: GERIATRICS AND EXTENDED CARE SERVICES *(If applicable)*

37. ☐ COMMUNITY ADULT DAY HEALTH CARE ☐ COMMUNITY NURSING HOME ☐ HOMEMAKER/HOME HEALTH AIDE
☐ HOME INFUSION ☐ HOSPICE/PALLIATIVE CARE ☐ RESPITE
☐ SKILLED HOME HEALTH CARE ☐ OTHER: _____

FREQUENCY & DURATION: _____

38. 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).*

SECTION VI: HOME OXYGEN INFORMATION *(If applicable)*

39. PA02 AT REST:	40. O2 SAT AT REST:	41. OXYGEN FLOW RATE:

42. EXTENT OF SUPPORT *(Continuous, Intermittent, Specific Activity)*:

43. OXYGEN EQUIPMENT *(Stationary/Portable)*:

44. DELIVERY SYSTEM *(Cannula, Mask, Other)*:

SECTION VII: DME & PROSTHETICS INFORMATION *(If applicable)*

45. HCPCS CODE(S) FOR ITEM(S) BEING PRESCRIBED:
E0652 qty 1, E0667 qty 2

46. BRAND, MAKE, MODEL, PART NUMBERS:
Bio Compression Systems SC-4008-DL 8 Chamber Sequential Gradient Pump & G-3045 S/M/L

47. MEASUREMENTS:

48. QUANTITY:	49. ICD-10:	50. PROVISIONAL DIAGNOSIS:

51. DELIVERY/PICKUP OPTIONS:
☐ DELIVER TO ORDERING PROVIDER'S ADDRESS ☐ VETERAN WILL PICKUP AT THE VA MEDICAL CENTER
☐ DELIVER TO COMMUNITY VENDOR FOR DELIVERY & SETUP FOR DME ☒ DELIVER TO VETERAN'S HOME

SECTION VIII: DURABLE MEDICAL EQUIPMENT *(DME)* EDUCATION & TRAINING *(If applicable)*

Please see DME/Pharmacy Requirements—Information for Providers - Community Care (va.gov) for URGENT DME requests.

NOTE: Failure to thoroughly complete the RFS for DME will result in delayed patient care & prevent the VA from DME fulfillment.

52. BEFORE DME WILL BE ISSUED, EDUCATION, TRAINING, &/OR FITTING OF DME *(as applicable for the specific DME being ordered)* TO THE VETERAN MUST BE COMPLETE. PLEASE INDICATE WHETHER THE FOLLOWING HAS BEEN COMPLETED FOR THE VETERAN.

NOTE: If not completed, DME will be mailed to requesting provider's address to coordinate an alternative time for proper instruction on DME use.

A. EDUCATION:	☒ YES	☐ NO	
B. TRAINING:	☐ YES	☐ NO	☒ N/A
C. FITTING:	☐ YES	☐ NO	☒ N/A

53. 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).*

I am placing a prescription for an E0652 lymphedema pump today. Patient has one or more of the following conditions: hyperpigmentation, hyperkeratosis, hyperplasia, elephantiasis, lymphorrhea, papilomatosis. The patient has tried 4 or more weeks of conservative therapy including elevation, compression garments of 20-30 mmHg, and exercise, but remains symptomatic.

VETERAN'S LEGAL FULL NAME *(First, MI, Last)*:

SECTION IX: THERAPEUTIC FOOTWEAR ASSESSMENT INFORMATION *(If applicable)*

54. FILL OUT THE INFORMATION BELOW *(If applicable)*:

☐ LEFT FOOT ☐ RIGHT FOOT ☐ BILATERAL

☐ PREFABRICATED THERAPEUTIC FOOTWEAR

☐ CUSTOM THERAPEUTIC FOOTWEAR

NOTE: For prescription of therapeutic footwear for severe or gross foot deformity which cannot be accommodated with conventional footwear.

DESCRIBE FOOT DEFORMITY AND ADDITIONAL DETAILS:

NOTE: For prescription of therapeutic footwear due to disease pathology resulting in neuropathy or peripheral artery disease.

55. CHECK APPROPRIATE DIABETIC/AMPUTATION RISK SCORE:

☐ **RISK SCORE 2:** PATIENT DEMONSTRATED SENSORY LOSS *(inability to perceive the Semmes-Weinstein 5.07 monofilament)*, DIMINISHED CIRCULATION AS EVIDENCED BY ABSENT OR WEAKLY PALPABLE PULSES, FOOT DEFORMITY, OR MINOR FOOT INFECTION, & A DIAGNOSIS OF DIABETES.

☐ **RISK SCORE 3:** PATIENT DEMONSTRATED PERIPHERAL NEUROPATHYWITH SENSORY LOSS *(i.e., inability to perceive the Semmes-Weinstein 5.07 monofilament)*, 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 *(PVD) (intermittent claudication, dependent rubor with pallor on elevation, or critical limb ischemia manifested by rest pain, ulceration or gangrene)*; (3) CHARCOT'S JOINT DISEASE WITH FOOT DEFORMITY; & (4) END STAGE RENAL DISEASE.

NOTE: Only patients who are experiencing medical conditions noted in the risk scores can be prescribed therapeutic/diabetic footwear.

***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.

56. REQUESTING PROVIDER SIGNATURE *(Required)*:

57. TODAY'S DATE *(MM/DD/YYYY)*:

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