



Spokane VA Medical Center

**Notification of  
Emergency Room or Observation Event  
Fax to (509) 434-7158**

TODAY'S DATE: \_\_\_\_\_

HOSPITAL NAME: \_\_\_\_\_

HOSPITAL FAX: \_\_\_\_\_

ER PHYSICIAN NAME: \_\_\_\_\_ Phone #: \_\_\_\_\_

DATE OF SERVICE: \_\_\_\_\_

VETERANS NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

SPECIALTY: MED \_\_\_ SURG \_\_\_ PSYCH: \_\_\_ REHAB: \_\_\_ OTHER: \_\_\_

ADDITIONAL INSURANCE  
INFORMATION: \_\_\_\_\_

**\*\*\*VETERAN'S STATEMENT: I request VA to provide payment for this episode of care in accordance with any benefit I may be eligible for through VA. I understand that if I am found to be eligible for payment by VA, I am subject to transfer to a VA or other Federal facility for this care.**

**Signature of veteran or family member:** \_\_\_\_\_

(Please do not write below this line, for VA use only)

Authorized: \_\_\_ Not Authorized: \_\_\_

Report of Contact entered: Yes No Denial Entered and Sent: Yes No

Forms Needed to be Completed: 10-10 \_\_\_ 10-10F/EZ \_\_\_ NSC Condition \_\_\_

Veteran Eligibility: \_\_\_ For SC Condition Yes No

Veteran Enrolled: Yes No VA Form 10-583(a) Completed? Yes No

Veteran meets 24 month criteria? Yes No