



Spokane VA Medical Center  
**INPATIENT ALERT**  
**Fax to (509) 434-7158**

**Please attach a copy of the Admission Face Sheet with this alert.**

Today's Date: \_\_\_\_\_

Hospital Name: \_\_\_\_\_ Fax #: \_\_\_\_\_

Admitting Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Admission Type: ER \_\_\_\_\_ Direct \_\_\_\_\_ Scheduled \_\_\_\_\_

Date patient presented to ER if different than admit date: \_\_\_\_\_

Patient Stable for Transfer? Yes No

Date of Admission: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Veterans Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Specialty: Med \_\_\_\_\_ Surg \_\_\_\_\_ Psych \_\_\_\_\_ Other (specify) \_\_\_\_\_

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

For more information, please contact the Integrated Care Management Office at (509) 434-7609