



Spokane VA Medical Center

REQUEST FOR ADDITIONAL OUTPATIENT SERVICES

Fax: (509) 434-7158

'NOTES MUST ACCOMPANY THIS REQUEST'

Today's Date: _____

Vendor's Name: _____

Vendor's Address: _____

Vendor's Phone: _____ Fax: _____ Tax Id: _____

Veteran's Name: _____ SSN: _____

Diagnosis: _____

Desired treatment, procedure, or referral: _____

Lab _____ X-ray _____ Rx _____ Other _____

Date of desired treatment, procedure, or referral: _____

Location of treatment if different from doctor's office: _____

Period of Care: Yes _____ No _____ (Indicate length of time and number of visits)

Surgical Procedure: Yes _____ No _____ (If yes, list CPT codes with cost estimates & ancillaries)

Comments: _____