OMB Number: 2900-0080 Estimated Burden: 2 minutes

Department of Veterans Affairs

AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

This information is collected under the authority of Title 38 1703, 1725 and 1728. In accordance with section 3507 of the **Paperwork Reduction Act** of 1995, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this invoice will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. The purpose of this form is to authorize medical treatment and provide a means to bill for this service although private providers may also use local billing forms or UB (Uniform Billing) Forms 92. Submission of this form is voluntary and failure to respond will have no impact on benefits to which you may be entitled. Comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing the burden, may be addressed by calling the Health Benefits Contact Center at 1-877-222-8387.

1A. DATE OF ISSUE	1C. DATE OF ISSUE (Month, day, year)												
(mm/dd/yyyy)						1D. VETERAN'S NAME (First, middle initia				al, last) (This is a mandatory field.)			
								,					
2. NAME OF PHYSICIAN O	3.	3. VETERAN'S CLAIM NUMBER				4. SOCIAL SECURITY NUMBER							
						C-							
	5. AUTHORIZATION VALID												
		FROM (mm/dd/yyyy)				TO (mm/dd/yyyy)							
ı			PART I - S	ERVICES A						7. FEE	I		
6. SERVICES SHOWN BELOW AUTHORIZED FOR PERIOD INDICATED IN ITEM 5 ABOVE. (See special provisions on back of form.)													
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8. FEE SCHEDULE OR CONTRACT 9. AUTHORITY				9A.						10. ESTIMATED AMOUNT			
				10 AUTUODI	7ED D	V (NI	170.						
11. FISCAL SYMBOLS 36			0160.001	12. AUTHORIZ	ZED B	Y (Name and	d Little)						
			PAR	<u>'</u> T II - INVOI	CE								
13. DATE(S) OF SERVICE	14. DESCRIPTION							rized, enter			5. FEE		
MONTH DAY YEAR	the remark "As Authorized Above" in this column. Otherwise, itemize services.) CLAIMED AMOUNT												
WONTH DAT TEAK		SERVICE FURNISHED											
									\$				
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15A. SOCIAL SECURITY NO) Individual or orga	nization f	furnishing servi	16. BILLIN						J			
OR EMPLOYER ID NO Individual or organization furnishing ser enter billing date and amount clair (Continue billing on back if necessary.)				ed. (mm/d	(mm/dd/yyyy) 17. TOTAL CLA			AL CLAIMED	\$				
	(Continue billing	on back if				\			Ψ				
PART III - FOR VA USE ONLY													
ADMINISTRATIVE CERTIFICATION						AMOUNT DUE DATE				BLOCK VOUCHER AUDITOR			
Payment of this will not cause payee to exceed maximum amount allowed. Services have been furnished as authorized or medically approved except as stated below.					-			VOUCHER AUDITOR					
						\$				<u> </u>			
REMARKS													
SIGNATURE AND TITLE DATE													
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PART IV - ACCOUNTING BLOCK ION PAT NO TC & SC CPF LIQ AMT 1ST SA \$ DATE/INITIALS													
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PART II - INVOICE (Continued)											
13. DATE(S) OF SERVICE	RVICE 14. DESCRIPTION OF SERVICE				15. FEE CLAIMED						
MONTH DAY YEAR		AMOUNT									
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, Diago o	nter total shown in 17A. Enter this	16. BILLING DATE	17A. TOTAL								
total in 1	nter total shown in 17A. Enter this 7on front of form also.		CLAIMED	\$							

SPECIAL PROVISIONS: Acceptance of this authorization to render service is governed by the following:

- ACCEPTANCE OF THIS AUTHORIZATION AND PROVIDING OF SUCH TREATMENT OR SERVICES SUBJECTS YOU, THE PROVIDER OF CARE, TO THE PROVISIONS OF PUBLIC LAW 93-579, THE PRIVACY ACT OF 1974, TO THE EXTENT OF THE RECORDS PERTAINING THE VA AUTHORIZED TREATMENT OR SERVICES OF THIS VETERAN.
- Fees or rates listed represent maximum allowance for services specified. In no event should charges be made to the VA in excess of usual and customary charges to the general public for similar services.
- * Payment by VA is payment in full for authorized services rendered.
- Unless otherwise approved by VA, services are limited in type and extent to those shown on the authorization. If services are not initiated for any reason, return a copy of the authorization to the issuing office with a brief explanation.
- * A copy of the Operative Report will be forwarded to the authorizing facility within 1 week following any major surgery.
- A copy of the hospital summary will be forwarded to the authorizing facility within 10 work days following the release of the patient from the hospital.

All questions relating to this authorization should be referred to the issuing VA Facility.

VA FORM
JUN 2007

10-7078

REVERSE

ORIGINAL