

## TRAINING MODULE 10 Study Plan

### VA MEDICAL CARE

#### Objective:

To learn about health and medical care benefits available to veterans and eligible family members, and how to apply for and obtain such benefits.

#### References:

Title 38, U.S. Code, Chapter 17

38 Code of Federal Regulations Parts: 17

VA Pamphlet 80-05-1, *Federal Benefits for Veterans and Dependents*

#### Instructions:

Study the assigned materials to learn how to assist veterans, eligible dependents, and survivors, to apply for and obtain necessary medical care and services from the VA healthcare system.

#### Summary:

Under the Veterans Health Administration (VHA), the Department of Veterans Affairs (DVA) operates one of the largest healthcare delivery systems in the world. The system consists primarily of centralized comprehensive medical centers, most of which are affiliated with university medical schools, complemented and supplemented by an extensive network of outpatient clinics and readjustment counseling centers, as well as nursing homes and domiciliaries.

In general, VA will provide health care, including medical or other treatment as required, to any honorably discharged veteran. VA will also furnish care to certain persons who received an other than honorable discharge from service, but only for a disability which was incurred in or aggravated by service, in line of duty [38 CFR §§ 3.360, 17.47(a)(2)]. VA medical facilities may furnish health care to certain veterans' dependents covered under CHAMPVA, as well as to military personnel and retirees and their families covered under CHAMPUS/TRICARE. VA will furnish needed care for problems related to spina bifida and certain other birth defects in eligible children of Vietnam veterans. Finally, VA medical facilities will furnish necessary emergency care, including hospital admission where required, on a humanitarian basis for any person regardless of status.

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To obtain medical care, or health care benefits in general, it is necessary to apply for them. This is done by submitting a completed VA Form 10-10, *Application for Medical Benefits*, or 10-10ez, *Application for Health Benefits*, to the nearest VA medical facility. Except in emergency situations, a veteran seeking care for a service-connected condition will generally take precedence over others. In all other cases, the priority of care is as follows:

1. Veterans with service-connected ratings of 50% or more.
2. Veterans with service-connected ratings of 30% or 40%.
3. Veterans with service-connected ratings of 10% or 20%;  
Former prisoners of war;  
Veterans who were awarded the Purple Heart for combat wounds or injuries;  
Veterans who were discharged from service for service-connected disability; and  
Veterans who have special eligibility under 38 USC 1151.
4. Veterans determined by VA to be catastrophically disabled, or veterans entitled to receive special monthly pension (aid and attendance or housebound).
5. Veterans with no service-connected disabilities and veterans with 0% service-connected ratings, who are determined to be unable to defray the costs of needed care.
6. Veterans entitled to compensation for 0% service-connected disabilities (includes veterans entitled to the 10% rate based on multiple 0% disabilities under 38 CFR § 3.324, veterans entitled to special monthly compensation under 38 USC 1114(k) for loss or loss of use of a creative organ, and veterans entitled to special monthly compensation under the former 38 USC 1114(q) for arrested tuberculosis);  
Veterans who served during the Mexican Border Period and/or World War I; or  
Veterans seeking care solely for conditions claimed to be associated with exposure to ionizing radiation or toxic substances during service (including service in the Persian Gulf area) or for any illness associated with participation in tests conducted by the Department of Defense as part of Project 112 or Project SHAD.
7. Veterans with no service-connected disabilities and veterans with 0% service-connected ratings whose family income and assets meet statutory thresholds for "low-income," and who agree to make specified co-payments.
8. Veterans with no service-connected disabilities and veterans with 0% service-connected ratings whose income and net worth are greater than the above thresholds, and who agree to make specified co-payments.  
Public Law 110-329 provides VA additional funding to allow expanded enrollment opportunity for certain Priority 8 veterans who may have been previously denied enrollment in VA's health care system because their income exceeded VA's means tests thresholds.

The new provision allows veterans whose incomes do not exceed these thresholds by more than 10 percent to enroll in VA's health care system. The new provision is expected to take effect this June and will be applied retroactively to all enrollment applications received on or after January 1, 2009. These changes do not open enrollment to all Priority 8 veterans.

To allow for planning and allocation of resources, all veterans applying to a VA medical facility for health care are required to enroll with VA, unless the veteran was discharged from service less than a year ago because of service-connected disability, even though VA has not yet rated it; or has a service-connected disability rated 50% or more; or is seeking treatment only for a service-connected disability. If budgetary resources require, enrollments may be deferred or discontinued for veterans in Priority Groups 7 and/or 8 on a year-by-year basis.

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On enrollment, the veteran will be assigned to one of the above priority groups, and is eligible for all needed inpatient and outpatient medical, surgical, and psychiatric services, including, but not limited to, drugs and pharmaceutical supplies, home healthcare, and hospice care.

To help you determine eligibility when helping a client complete the application 10-10EZ or EZR you can log into the VA calculator web page at <http://www.va.gov/healtheligibility/apps/enrollmentcalculator/index.asp>. The veteran may choose a preferred facility for receiving primary care. The enrollment is for one year, and is automatically renewed each year unless the veteran requests that it not be renewed.

In general, a veteran must obtain health care from a VA medical facility, if reasonably available (usually considered as being within 30 miles of the veteran's residence). If the VA medical facility is unable to provide a needed service in a particular case, VA may either contract with local facilities to provide the service or send the veteran (at VA expense) to the nearest VA medical facility that can provide the service. If no VA medical facility is reasonably available, VA may authorize the veteran to obtain specified care locally on a fee basis. If the veteran's service-connected disability is rated 50% or more, fee basis care may be authorized for any condition. If the service-connected rating is less than 50%, fee basis care may be authorized only for service-connected condition(s). Fee basis care must be authorized in advance in all cases.

If a veteran should require emergency treatment or admission to a non-VA medical facility for a service-connected condition, VA will reimburse the charges incurred provided the VA medical facility of jurisdiction is notified within 72 hours of such treatment or admission. VA will also reimburse cost of emergency treatment at a non-VA medical facility for a nonservice-connected condition, provided that:

- The veteran is currently enrolled in the VA Health Care system;
- The condition in question has been treated (by VA) within the previous two years; and
- The veteran is not covered under any other health services plan.

The only other circumstances under which VA will reimburse unauthorized expenses (emergency or otherwise) for a nonservice-connected condition are: if the veteran is rated permanently totally disabled from service-connected disabilities (whether 100% or by reason of individual unemployability), or if the veteran is enrolled in a program of Vocational Rehabilitation and it is medically determined that the treatment is required for the veteran to continue training. If VA agrees to reimbursement of unauthorized charges and the veteran requires prolonged hospitalization, VA will require transfer to a VA medical facility as soon as the veteran's condition permits.

VA will pay travel pay at common carrier rates for certain veterans to travel to and from a VA medical facility for the purpose of examination and/or treatment (including hospitalization) with a \$3 deductible per trip, up to a maximum deductible of \$18 per calendar month. Persons who qualify for travel pay include:

- Veterans seeking examination and/or treatment specifically of a service-connected condition, regardless of its percentage;
- Veterans who have a service-connected rating of 30% or more overall, for any condition;
- Veterans in receipt of VA pension, or whose income is below the statutory limits for VA pension and who are unable to defray the costs of travel;
- Veterans who have been scheduled for a Compensation and Pension (C & P) or other special purpose examination; and

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- Veterans who require a specialized mode of transportation such as an ambulance, wheelchair van, etc., provided that:
  - A physician has determined that the veteran requires the specialized mode of transport;
  - The veteran is unable to defray the cost of the specialized transport, and
  - The travel has been authorized in advance.

Veterans who must travel to a C & P examination and veterans who require special modes of transportation are exempted from the deductible requirement; in other cases, the deductible may be waived on a showing that it would cause the veteran undue hardship. For veterans requiring specialized modes of transport, travel pay may also include the costs of meals and lodging en route, as well as the cost of an attendant. Prior travel authorization is required except in the event of a medical emergency or other circumstance where a delay would be hazardous.

Limited outpatient dental services are available at VA medical facilities. Veterans who are rated totally disabled from service-connected conditions (whether 100% or because of individual unemployability), former prisoners of war (with no distinctions based on length of captivity, beginning December 6, 2003), and veterans who have a service-connected dental disability of compensable severity are entitled to any and all necessary dental care. Veterans who are participating in a program of Vocational Rehabilitation are entitled to any dental treatment necessary for them to continue in their program. Veterans who suffered dental trauma in service, whether in combat or otherwise, are entitled to any necessary treatment for the specific teeth for which noncompensable service connection is established.

Other veterans with noncompensable service-connected dental disabilities are entitled to whatever treatment may be necessary for the one-time correction of the service-connected dental condition, provided they meet the length of service requirements and they make application to the Dental Clinic within 90 days after discharge from service. Veterans being treated for other conditions, whether as an inpatient or outpatient, may receive dental care which is medically necessary; that is, for a dental problem which is complicating the medical condition currently under treatment.

All VA medical facilities have special programs and services for female veterans. In addition to regular generic medical services, there is also a full array of gender-specific services for female veterans, such as gynecological (breast and pelvic) examinations and reproductive health care counseling. Preventive health care for female veterans includes contraceptive services, PAP smears, mammography, and menopause management. Counseling and therapy are also available for women who suffered sexual trauma during service. Some, but not all, VA medical facilities may offer maternity services. If a particular VA facility does not have a certain service available, it will either contract the service out or provide a community referral. There is a Women's Program Coordinator at each VA medical facility.

VHA provides extensive specialized rehabilitation services for severely disabled veterans. The Western Blind Rehabilitation Center is located at the VA Medical Center at Palo Alto, and provides extensive rehabilitation services for blind veterans throughout much of the state of California.

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There is another Blind Rehabilitation Center at the VA Medical Center in Phoenix, Arizona. Rehabilitative services from these centers are provided on an inpatient and outpatient basis, as well as through community-based organizations, for qualified blind veterans regardless of whether the blindness is service-connected. Members of the Visually Impaired Services Team (VIST) are assigned to many VA outpatient clinics for outreach purposes, and there are also VIS coordinators at all VA medical facilities. For veterans with diseases or injuries of the central nervous system, the VA Medical Centers at Long Beach and Palo Alto provide special rehabilitative services by the Brain Injury Unit and the Spinal Cord Injury Unit.

For veterans who are not acutely ill and do not require hospitalization, but who do require medium-to-long term custodial and/or skilled nursing care, VA has Nursing Home Care Units associated with some medical centers. Admission is on a space-available basis, with first priority given to veterans whose service-connected disability requires this level of care. Other veterans are considered in order of their priority groups.

If a veteran requires nursing home level of care and space is not available in a VA Nursing Home Care Unit, VA may place the veteran in a civilian nursing home under VA contract, as a VA beneficiary. A VA nursing home contract normally will not be for longer than six months, unless the condition requiring nursing home care is service-connected, or the veteran was hospitalized for a service-connected disability and then transferred to the nursing home. Under certain limited circumstances a veteran may be admitted directly to a civilian nursing home as a VA beneficiary.

Finally, VA may provide domiciliary care for veterans who are able to perform basic self-care tasks and require only low-level nursing, rehabilitation, and/or custodial services. Eligibility for admission to a domiciliary is income-based: the veteran's annual income may not be more than the maximum VA pension rate, or the veteran must be shown to have no adequate means of support. Only some VA Medical Centers offer domiciliary care; there are also VA domiciliaries which are not associated with a VA medical facility.

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The Omnibus Budget Reconciliation Act of 1990, provides that veterans receiving medications on an outpatient basis from VA facilities, for the treatment of a nonservice-connected disability or condition, are required to make a co-payment of \$8.00 for each 30-day or less supply of medication provided. Veterans receiving medications for treatment of a service-connected condition and veterans rated 50 percent or more service-connected are exempt from the co-payment requirement for medications.

The Department of Veterans Affairs is authorized to bill insurance carriers for the cost of medical care furnished to all veterans for nonservice-connected conditions covered by health insurance policies. Veterans are not responsible and will not be charged for any co-payment or co-insurance required by their health insurance policies.

#### DENTAL SERVICES: 38 CFR § 17.160

Dental services are provided by the Department of Veterans Affairs (VA) to veterans on an outpatient basis under the following conditions:

1. Veterans are considered eligible and may apply at any time for outpatient dental services if:
  - a. Veteran receives service-connected compensation for a dental condition or disability
  - b. Veteran is rated at 0% for service-connected dental conditions which are the result of combat wounds or service injuries.
  - c. Veteran was a prisoner of war, with no distinctions based on length of captivity.
  - d. Veteran receives, or is entitled to receive but for military retired pay, disability compensation at the 100 percent rate for one or more service-connected conditions, or is rated service-connected and totally disabled because of individual unemployability.
  - e. Veteran dental condition is non-service connected and it is determined by the VA to be associated with and aggravating a service-connected condition.
  - f. Veteran is participating in a VA vocational rehabilitation program.
  - g. Certain enrolled homeless veterans participating in specific health care programs.
  
2. Veteran must apply within 90 days of separation from active duty if his/her dental conditions or disabilities are shown to have been in existence at the time of his/her discharge or release from active service of at least 180 days. (DD-214 must state Dental Care Not Provided).

Dental treatment claimed is for a nonservice-connected condition and dental treatment was begun while receiving hospital care at VA expense, and it is professionally determined to be reasonably necessary to complete the remainder of this dental care on an outpatient basis.

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**DESIGNATED SPECIALTY CENTERS:**

The Department of Veterans Affairs maintains Specialty Centers (for blinded, paraplegic, amputees, alcoholic, drug addicted, etc.), the nature and location of which can be obtained from any VA field station, or your NCDVA hospital or clinic representative.

**ADMISSION OF ALCOHOLIC AND DRUG ADDICTED VETERANS TO  
VETERANS AFFAIRS HOSPITALS:**

Requests for hospitalization for the treatment of alcoholism and drug addiction will be medically and administratively processed in the same manner as requests for admission for treatment of any other disability, disease, or defect susceptible to cure or decided improvement, except that all eligible applicants for hospitalization for drug dependence will be classified as medical emergencies.

**BENEFICIARY TRANSPORTATION:**

Under the Veterans Benefits and Services Act of 1988, Public Law 100-322, new travel provisions were implemented. Under this law all VA Medical Centers and facility directors will ensure promulgation of policies and procedures pertinent to beneficiary travel commencing July 1, 1988.

1. Beneficiary travel payments shall be made to the following categories of VA beneficiaries:
  - a. A veteran or other person traveling in connection with treatment for a service connected disability, subject to the deductible.

Note: "other person" is defined to include a veteran's non-employee attendant; a dependent or survivor receiving care in a VA facility; or members of the immediate family, the legal guardian or an individual in whose household the veteran lives or intends to live when receiving counseling or mental health services in conjunction with the veteran's care.

- b. A veteran with a service-connected disability rated at 30 percent or more, for treatment of any condition, subject to the deductible.
- c. A veteran receiving VA pension benefits, subject to the deductible.
- d. A veteran whose annual income (as determined under 38 U.S.C. 503) does not exceed the maximum annual rate of pension which would be payable if the veteran was eligible for pension, subject to the deductible.

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- e. A veteran or other person whose travel is medically required to be performed by a special mode of travel and who is unable to defray the expenses. The deductible does not apply.
  - f. A veteran whose travel is incident to a scheduled compensation and pension examination. The deductible does not apply.
2. Beneficiary travel payments shall be made to eligible beneficiaries for the following purposes:
- a. Reimbursement, less deductible, for scheduled outpatient visits and admissions:
    - 1) Mileage reimbursement or the cost of travel by common carrier, whichever is less, will be paid for only scheduled outpatient visits or admissions.
    - 2) Mileage reimbursement for categories of veterans described in paragraph 1.a,b,c, and d, is subject to a deductible of \$6 (round-trip) for each visit, not to exceed \$18 per calendar month. Veterans who are required to make more than three round-trip visits per month will receive full reimbursement once the \$18 deductible cap is met.
  - b. Scheduled compensation and pension examinations. Furnish all transportation and other expenses incident to scheduled compensation and pension examination. (no deductible)
  - c. Medically indicated specialized modes of transportation

The VA shall pay the cost of specialized modes of transportation when a VA physician determines it is medically required, and it is authorized before travel begins, and the veteran or other person is unable to defray the cost. Medical emergencies do not require preauthorization as defined in paragraph 1.e.

**Note:** "unable to defray the cost" is defined to include veterans or other person traveling in connection with a service-connected disability, veterans who are service-connected 30% or more, veterans in receipt of VA pension, or whose annual income does not exceed the maximum annual rate of pension which would be payable if the veteran were eligible for pension. The deductible does not apply. Special mode includes ambulance, air ambulance, wheelchair van, or other modes of transportation which are specially designed to transport certain types of medically disabled individuals. Special mode does not include public transportation such as a bus, subway, train, airplane, or privately owned conveyance.

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- d. Medical emergency-When delaying immediate transportation would be hazardous to the patient's health or life, a specialized mode of transportation may be authorized by a VA physician before eligibility is determined. Payment may be made to the provider of the transportation, subject to subsequently recovering the amount of the payment from the veteran if the veteran were determined to be ineligible.
- e. Interfacility transfer-When necessary to transfer the inpatient from one health care institution (either VA or a contract care facility) to another, provided both institutions furnish the individual with treatment at VA expense, or under VA auspices, and the transfer is necessary for the continuation of such treatment, use of hired car, or a taxi is authorized, provided these are less expensive than other modes of travel.

**Note:** Eligibility criteria and deductibles do not apply. All care required for inpatients is the responsibility of the VA.

**Ambulance Travel:** It cannot be emphasized too strongly to avoid difficulties in reimbursement that prior authorization for ambulance travel must be obtained. It is important to obtain the name of the person in the VA authorizing transportation. We are outlining below a short summary of the procedure to be followed:

When a veteran, his attending physician, or his representative contacts a VA clinic, center or hospital requesting emergency ambulance, the chief medical officer, or his designee, will get all information possible about the case, and after weighing the facts, make final decision on the necessity for ambulance service and grant such service unconditionally if warranted.

Authority for ambulance service may be unconditional except where, from the information available, a determination cannot be made that the applicant is in fact a veteran. Only in cases where there was misrepresentation of facts on the part of the attending physician, the veteran, or his representative, will there be a reversal of the authority granted.

When a veteran is brought by ambulance to a VA hospital in which the VA has beds allocated for admission for a service-connected disability, and his condition is such that ambulance service was necessary, reimbursement for the cost of ambulance service may be authorized when the delay caused in obtaining prior authority might have resulted in endangering the veteran's life.

When a VA clinic or sub-clinic, center, or hospital receives a call for emergency ambulance service for a veteran and a VA contract ambulance service is not available or practical, the chief medical officer or his designee is authorized to pay such charges for ambulance service not in excess of that charged the general public for such service in the area in which the veteran resides.

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**ELIGIBILITY AND HOW TO APPLY FOR A DEPARTMENT OF VETERANS**  
**AFFAIRS**  
**FEE BASIS I.D. CARD**

**ELIGIBILITY**

- A. Service-connected veterans
- B. Veterans in receipt of SMP
- C. World War I veterans
- D. Requires recurrent outpatient medical treatment
- E. No Department of Veterans Affairs (VA) facilities available or the VA facility cannot treat the medical condition

**APPLICATION**

- A. Submit VA Form 10-10 (Marked Fee Basis Card)
- B. Submit, if possible, a doctor's report on treatment needed. This will help the veteran speed up the process
- C. Submit VA Form 10-101 (Insurance Worksheet)
- D. Mail to: Nearest VA Medical Center

**How to use a Fee-Basis card once issued**

- A. Veteran must locate the Physician of his/her choice who is willing to participate in the Fee Program
- B. Payment is limited to \$125.00 per month for the conditions listed on the Fee Basis Card
- C. If the Fee Physician wants to perform a procedure that will exceed the \$125.00 limit, he must obtain prior approval by submitting a written treatment plan with medical justification to the following address: Medical Center where enrolled.
- D. Physician should be willing to accept Fee Schedule payments as Paid in Full.
- E. Veteran should not be billed any balances for services beyond what the Fee Schedule allows unless the services were for unapproved conditions. In that case the VA will not pay.

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#### Special Notes

- A. Fee Basis I.D. Cards are for outpatient treatment only (no dental, hospitalization, prosthetic, or any other purposes).
- B. All veterans will be re-evaluated periodically to determine continuation of Fee Basis care. Fee Basis is not a permanent status for any veteran.

#### Insurance Information

The VA will bill insurance companies for medical care provided for all non-service connected disabilities.

Example:

1. Veterans with aid and attendance or who are housebound and WWI veterans whose only entitlement is non-service connected.
2. Veterans who are rated 50% service-connected or more and are authorized treatment for non service connected conditions; the VA will bill insurance companies for the non-service connected conditions.
3. VA will not bill the veteran if the insurance carrier does not pay.

#### Eligibility and How to Apply for VA Authorization of Emergency-Outpatient Treatment

- A. Service-connected 50% - 100%  
Any Emergent condition
- B. Service-connected less than 50%  
Emergent treatment for service-connected conditions only
- C. A & A, Housebound, or WWI veterans  
Any Emergent condition
- D. VA facilities are not feasibly available
- E. Must be reported within 15 days from the date of Emergent condition
- F. Notification of such Emergency may be made by telephone, telegram or letter

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- G. When submitting for payment, veteran must submit all invoices, emergency room report or doctors' report; and must substantiate the existence of a medical Emergency
- H. Notification must be made to the VA Medical Center in which the veteran is enrolled.

### Non-Service Connected Emergency Care Benefits

The VA will now pay for emergency care rendered for non-service-connected conditions for enrolled veterans who have no other source of payment for the care. If facilities accept VA reimbursement it is considered payment in full and qualifying veterans will not be held responsible for hospital charges. This benefit is a safety net for enrolled veterans who have no other means of paying a private facility emergency bill. If another health insurance provider pays all or part of a bill, VA cannot provide any reimbursement.

#### How to qualify:

To qualify you must meet all of the following criteria.

- A. You are enrolled in the VA Health Care System
- B. You have been provided care by a VA Clinician or provider within the last 24 months
- C. You were provided care in a hospital emergency department, or similar facility providing emergency care.
- D. You have no other form of health insurance
- E. You do not have coverage under Medicare, Medicaid, or a state program.
- F. You do not have coverage under any other VA programs.
- G. Department of Veterans Affairs or other Federal facilities are not feasibly available at time of emergency event.
- H. A reasonable lay person would judge that any delay in medical attention would endanger your health or life.
- I. You are financially liable to the provider of the emergency treatment for that treatment.
- J. You have no other contractual or legal recourse against a third party that will pay all or part of the bill.
- K. You, your representative or the medical facility should contact the nearest VA Medical Center as soon as possible.
- L. VA will only pay the private facility until your condition stabilizes.

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#### Eligibility and Procedures to File a Claim for Unauthorized Emergent Outpatient Medical Services

- A. Emergent treatment for a service-connected disability
- B. Emergent treatment for any condition for veterans rated permanently and totally disabled due to a service-connected disability (no future exam scheduled).
- C. VA facilities must not be feasibly available
- D. Medical condition must be of such an emergent nature that any delay in obtaining treatment would have been hazardous to the veteran's life or health.
- E. Payment request must be received by the VA within 2 years of the date of Treatment

#### *How to File*

- A. All bills, vouchers, invoices, or receipts or other documentary evidence establishing that such amount was paid.
- B. Emergency room reports
- C. An explanation of the circumstances necessitating the use of private emergent medical care

**Submit to:** Medical Center where enrolled.

How to use VA Pharmacy to file non-VA prescriptions Fee Basis I.D. Card Participant

- A. Veterans being treated by private physicians at VA expense on Fee Basis

Must send prescriptions to: Medical Center where enrolled.

- B. Mail-out pharmacy will substitute with Generic Drugs where medically feasible.

**How to obtain reimbursement, for prescriptions filled at non-VA pharmacies for Fee Basis Medical I.D. Card participants**

- A. Acute Illnesses-One Time Basis
- B. Veteran needs to submit an itemized receipt and should include:
  - 1. Veteran's name, social security next number, and mailing address
  - 2. Date prescription was provided

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3. Name, strength, and quantity of each drug along with amount paid
4. Prescription number of drug
5. Name and address of pharmacy
6. Name and address of prescribing physician
7. Receipted statement marked paid
8. Certification by the prescribing physician with the statement that "This medication order is needed immediately for the patient's disability which the VA has authorized me to treat"

Mail to: Medical Center where enrolled.

**Note:** For Emergent 10-day supply of new prescriptions call this number in advance:  
(1-877-354-5196)

### Eligibility and How to File an Unauthorized Private Hospitalization Claim

- A. Notification after 72 hours of emergent private hospitalization
- B. Emergent service-connected condition.
- C. If veteran is rated 100% permanent and totally disabled due to a service-connected disability for any emergent condition.
- D. VA facilities were not available

### How to File

1. Emergency room report, if any
2. Hospital admission notes, history, and physical report.
3. Physician's daily progress notes
4. Hospital discharge summary
5. VA Form 10-583 completed by each provider of care.
6. VA Form 10-583 from veteran requesting reimbursement with itemized invoices showing any balance due (to include payments made by Medicare, insurance, or veteran).

Mail completed claims to: Medical Center where enrolled.

Remember payment will only be made to the date when the veteran's condition improved to the point that the patient could be safely transferred to a VA Medical Center.