VA or Hospice
Verbal Approval Form

Facility: _____

Facility Therapy Supervisor: _____

Patient Name: _____ DOB: _____

Primary MD: _____

Disciplines ordered: [ ] PT [ ] OT [ ] ST

Payer Source: [ ] VA: _____
(name of VA, contact person, and phone #)

[ ] Hospice: _____
(name of Hospice, contact person, and phone #)

Representative's Name: _____

Contacted on: _____ [ ] Eval authorized [ ] Eval not authorized

Eval sent to Representative on: _____

Verbal authorization received on _____ for:

[ ] PT _____x/wk for _____ wks

[ ] OT _____x/wk for _____ wks

[ ] ST _____x/wk for _____ wks

[ ] Therapy not authorized