OMB Control Number: 2900-0823
Burden: 10 Minutes

U.S. Department of Veterans Affairs
Veterans Health Administration
*Office of Community Care*

# NON-VA HOSPITAL EMERGENCY NOTIFICATION

(TO BE COMPLETED WITHIN 72 HOURS OF THE BEGINNING OF TREATMENT)

COMPLETE AND RETURN THIS FORM WHEN A VETERAN PRESENTS EMERGENTLY TO YOUR FACILITY

RETURN TO: VHAEmergencyNotification@va.gov

## PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of 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 form will average 10 minutes. This includes the time it will take to read instructions, gather the necessary facts, and fill out the form.

**Privacy Act Information:** VA is asking you to provide the information on this form under 38 U.S.C. Sections 1703, the Veterans Community Care Program, when a veteran presents emergently at your facility. Information you supply may be verified from initial submission forward through a computer matching program. VA may disclose the information that you put on the form, as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may result in a delay or denial of your health care benefits under the Veterans Community Care Program. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA with your Social Security Number, VA will use it to administer your VA benefits. VA also may use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

Today's Date:

## VETERAN INFORMATION

Last Name:

First Name:

Date of Birth:

Social Security Number:

### HOME ADDRESS

Street:

City:

State: Zip:

### OTHER INSURANCE

◯ Yes ◯ No

Carrier:

Policy #:

## VENDOR INFORMATION

Facility Name:

Facility NPI:

Facility Tax ID:

Facility Phone #:

### FACILITY POC TO WHOM VA DECISION WILL BE SENT

Full Name:

Phone #:

Email:

### FACILITY ADDRESS

Street:

City:

State: Zip:

## EPISODE INFORMATION

Date / Time of Emergency:

Mode of Arrival:

Admitted? ◯ Yes ◯ No

Discharge Date:

**ONE OR MORE OF THE FOLLOWING IS REQUIRED**

Chief Complaint:

Admit DX:

Discharge DX?