



REQUEST FOR PAYMENT OF BOWEL AND BLADDER SERVICES

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. 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.

PRIVACY ACT INFORMATION: Information on this form is collected in accordance with the System of Records Notice 23VA10NB3 Non-VA Care (Fee) Records-VA (FR: Thursday, July 30, 2015). **Category:** Records maintained in the system include veterans seeking healthcare services under title 38 U.S.C. Chapter 17. **Authority:** 38 USC Veteran Benefits. **Purpose:** Records may be used to establish, determine, and monitor eligibility to receive VA benefits and for authorizing and paying Non-VA healthcare services furnished to veterans and beneficiaries. **Routine Use:** Relevant identifying and medical treatment information may be disclosed to a Federal agency or non-VA healthcare provider or institution, including their billing or collection agent, when VA refers a patient for treatment or medical services, or authorizes a patient to obtain non-VA medical services and the information is needed by the Federal agency or non-VA institution or provider to perform the services, or for VA to obtain sufficient information in order to consider or make payment for health care services, to evaluate the services rendered, or to determine the need for additional services. **Disclosure:** Voluntary. Failure to furnish the requested information will have no adverse impact on VA benefits.

Information on this form is collected in accordance with the System of Records Notice 186VA10D Community Care (CC) Provider Profile Management System (PPMS)-VA (FR Monday, January 25, 2021). **Category:** VA health care providers and Non-VA health care providers **Authority:** Public Law 104-191; 5 U.S.C. 301; 38 U.S. Code Sec. 1703; 45 Code of Federal Regulations (CFR) part 164; and 4 CFR 103. **Purpose:** Records may be used to establish, determine, and monitor eligibility to receive VA benefits and for authorizing and paying Non-VA healthcare services furnished to veterans and beneficiaries. **Routine Use:** Relevant identifying and medical treatment information may be disclosed to a Federal agency or non-VA healthcare provider or institution, including their billing or collection agent, when VA refers a patient for treatment or medical services, or authorizes a patient to obtain non-VA medical services and the information is needed by the Federal agency or non-VA institution or provider to perform the services, or for VA to obtain sufficient information in order to consider or make payment for health care services, to evaluate the services rendered, or to determine the need for additional services. **Disclosure:** Voluntary. Failure to furnish the requested information will have no adverse impact on VA benefits.

VETERAN'S NAME <i>(First & Last)</i> :	VETERAN FULL ICN*:	
PROVIDER NAME:	MONTH/YEAR INVOICED <i>(MM/YYYY)</i> :	PROVIDER PHONE NUMBER:
ADDRESS:	PROVIDER TIN NUMBER:	PROVIDER NPI:
	REFERRAL NUMBER*:	

BOWEL AND BLADDER CARE PROVIDED *(For dates and time noted below)*

DATE	HOURS	MINUTES	DATE	HOURS	MINUTES
1st			17th		
2nd			18th		
3rd			19th		
4th			20th		
5th			21st		
6th			22nd		
7th			23rd		
8th			24th		
9th			25th		
10th			26th		
11th			27th		
12th			28th		
13th			29th		
14th			30th		
15th			31st		
16th			TOTAL		
			COMBINED TIME FOR MONTH		

I hereby certify, this is a true account of time spent providing bowel and/or bladder care to the above-named Veteran. By the signature below, Provider acknowledges that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to 18 U.S.C. §§ 287 and 1001.

PROVIDER SIGNATURE:	DATE <i>(MM/DD/YYYY)</i> :
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*See VA Referral Form 10-7080

This form is intended for use by Individual B&B Providers certified through the VA's Spinal Cord Injuries and Disorders Program.