



Choice Program - Claims Service Summary

Veteran's Name:		DoD ID/Benefits # or Sponsor SSN:	
Date Completed:		VA Auth Number:	
1. Veteran's Address:		2. Patient DOB: Age:	
2. City:		State: Zip:	
3. Telephone:		Telephone:	
4. Veteran's Service Branch: <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> USAF <input type="checkbox"/> USMC <input type="checkbox"/> USCG <input type="checkbox"/> Other			
5. Other Insurance: <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please specify:			
6. Provider Name:		License Type:	
7. Provider Telephone:		Fax:	
8. Provider Address:			
City:		State: Zip:	
9. Provider TIN:		Provider NPI:	
10. DSM-V Diagnosis		11. Co-Occurring Medical Conditions (Relevant to Treatment)	
1. _____		1. _____	
2. _____		2. _____	
3. _____		3. _____	
12. Has the patient had a psychiatric hospitalization in the last 90 days: <input type="checkbox"/> yes <input type="checkbox"/> no			
13. <u>Dates of Service</u> <u>Service (CPT Code)</u> <u>Service Description (e.g., CBT, CPT, DBT, etc.)</u>			
(1)			
(2)			
(3)			
(4)			
14. TREATMENT PROGRESS: (Brief statement of client's engagement and participation in treatment)			
15. TREATMENT PLAN CHANGES: (Please note changes and revisions ONLY)			

Provider Signature: _____ Credentials: _____ Date: _____

Please fax the completed form to: 1-866-284-3736 or Upload via the Provider Portal

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services. Privacy Act Statement - This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations of this may be punishable by fines, imprisonment, or both.