



ALASKA VA

**NATIVE HEALTH SHARING AND
REIMBURSEMENT AGREEMENT**

GUIDEBOOK

SERVING AMERICA'S

VETERANS

[http:// www.alaska.va.gov](http://www.alaska.va.gov)

(Click on Patients & Visitors, Patient Information, Billing
& Insurance, located in the Resource section right side)

Updated June 2013

Table of Contents

3	VA/Native Sharing and Reimbursement Agreement
3	Veteran Enrollment Process/Eligibility Verification
4	AN/AI Direct Care Outpatient/Emergency Medical Services
4	AN/AI Referral Management to a Non Native Facility
4	Alaska Veterans Healthcare Clinics/Catchment Areas
5	Non AN/AI Pre-Authorization/Notification Process
6	Care with Special Eligibility
7	Travel
8	Pharmacy
9	Billing/Reimbursement
10	Co-pay
11	VA Departments and Extensions
13-19	Flow charts and Forms

VA/Native Sharing and Reimbursement Agreement

The Sharing Agreements between Alaska VA Healthcare System (AVAHS) and the Alaska Tribal Health Programs set for the terms and conditions under which AVAHS will authorize and reimburse the Native Health Program for direct services provided to eligible Veterans.

This Guidebook outlines the process and procedures to operate the Agreement between partnering Native Health Programs and the Alaska VA Healthcare System. The goal of the Agreement is to increase access to Alaska Veterans. Types of care provided under the Agreements include; outpatient medical and mental health, inpatient care, ambulatory surgery, and other services available in VA benefits package.

Veteran Enrollment Process/Eligibility Verification

A Veteran must be enrolled in the VA healthcare system prior to services being rendered in order for the AVAHS to authorize and/or reimburse for healthcare services. The application form (VA Form 10-10 EZ) can be obtained online, by visiting, calling or writing any VA health care facility or Veterans' benefits office. Depending on the method of application chosen by the Veteran the following are ways the VA can receive and process the application:

(1) Applications being mailed to the facility should be sent to the following address:

**Department of Veterans Affairs
Alaska VA Healthcare System
ATTN: Eligibility Department
1201 North Muldoon Road
Anchorage, AK 99504**

(2) Applications with signature can be faxed to 907-257-6784.

(3) Forms can be accessed online by going to this website:

<https://www.1010ez.med.va.gov/sec/vha/1010ez/>

Some Veterans are required to provide a financial assessment (Means Testing) as part of the enrollment process. Normally, Veterans that do not have a service connected condition are required to complete this as part of the enrollment process. Additionally, Veterans are normally required to provide their Means Testing annually there-after.

A DD 214 (Report of Separation) accompanying the request can help speed the process of verification and enrollment. If a Veteran has misplaced or lost their DD 214, then the application can still be processed, but may delay the notification process. A Veteran can request another copy to be sent to them by completing SF-180, which is accessible at the Alaska VA Website (address on cover of this document), in person at the Alaska VA, or also online at: <http://www.archives.gov/veterans/military-service-records/>. The Health Eligibility Center in Atlanta, Georgia is the final authority of Veteran enrollment or status.

Unless there is an urgent need it is requested to give the VA system at least two weeks to process a Veteran for enrollment. A Veteran may check the status of their enrollment by calling the Alaska VA at 907-257-4700, (Option 6 and then Option 3), which will be answered by one of the clerks if available or go to a message line. The eligibility office will respond to message line calls within 24 hours.

AN/AI Direct Care Outpatient/Emergency Medical Services

Preauthorization is not required for AN/AI eligible Veterans receiving Direct care services from the partnering Native Health Program. A Veteran must be eligible for VA Healthcare services and the service must be included as part of the Veterans Benefits package.

AN/AI Referral Management to a Non Native Facility

When a Native health care facility needs to refer a AN/AI Veteran for services not available within the AK Native health care system, this care **Must Be Preauthorized**. A “Request for Authorization” form should be faxed to Integrated Care Service, fax 907-257-7479.

Clinical documentation must be attached to the “Request for Authorization” form. Clinical documentation should include at a minimum a Diagnosis list, Medication list, progress notes from the visit requesting the referral and any ancillary testing results that the receiving provider would need to care for the patient.

Once Integrated Care Service receives the “Request for Authorization” form and clinical documentation, and it has been determined the Veteran is eligible for VA healthcare services, they will determine whether the care can be provided within a federal facility or if Non VA care will be purchased. The Veteran will be called to coordinate the appointment time and/or to select a Non VA provider. The Veteran will be mailed a copy of the authorization and an Authorization Letter. The Non VA care provider will be faxed a copy of the authorization and the supporting clinical documentation.

Alaska Veterans Healthcare Clinics/Catchment Areas

The Alaska VA Healthcare System has clinics in the following areas:

- Anchorage VA Medical Center
- Fairbanks VA Community Based Outpatient Clinic (located on Ft. Wainwright in Bassett Army Community Hospital).
- Mat-Su VA Community Based Outpatient Clinic (Wasilla)
- Kenai VA Community Based Outpatient Clinic and Homer VA Outreach Clinic
- Juneau VA Outreach Clinics.

If a Non AN/AI resides in a VA clinic catchment area and desires to utilize their VA benefits for their health care, s/he must go to one of the VA clinic's for primary care and/or any specialty care. **See Attached Catchment Area documents.**

The following services are available at the VA/Joint Venture clinic in Anchorage and/or the MatSu CBOC:

Primary Care
Alcohol and Drug Treatment Programs
Ambulatory surgery (limited)
Audiology and Speech Pathology
Care Management
Cardiology (limited)
Dental (Limited eligibility)
Social & Behavioral Services
Diabetic Education
Dermatology (limited)
Emergency Room Services (Joint Venture only)
Gastroenterology (limited)
Laboratory
Mental Health
Neurology (limited)

Ophthalmology (limited)
Orthopedics (limited)
Pharmacy
Physical Therapy
Podiatry
Prosthetics and Sensory Aids
Radiology
Women's Health Services
Urology
Vascular Services

Other services at the VA:
Back Care Classes
Dietician consults
Cholesterol and Hypertension
Classes
Lifestyle Changes – A Healthy
Heart
Hepatitis C Classes
Coumadin Clinic
Diabetic instructions
Patient Education Resource
Center (PERC)

**Services available at the
Fairbanks/Kenai/Homer/Juneau VA
clinics:**

Primary Care
Audiology (Limited)
Care Management
Mental Health
Orthopedics (Limited)
Women's Health Services
Podiatry (Limited)
Telemedicine limited

Non AN/AI Pre-Authorization/Notification Process

In order for Non AN/AI Veterans to be eligible for VA coverage for hospitalization, emergency room care or preauthorized outpatient care, the Veteran must be enrolled with the VA at the time service. **If enrollment has lapsed or if the Veteran has never applied for healthcare benefits, the care cannot be covered by the VA.** The Veteran may apply for enrollment at the time of admission, but it will go into effect after discharge.

Hospitalizations/Emergency Room visits: VA must be notified within 72 hours of a hospitalization or ER visit in order to be reviewed under Alaska's expanded Non VA care authority. When VA is not notified within 72 hrs, there is limited authority to approve the care.

Please submit notification of emergent medical care or hospitalizations by letter, phone call, or facsimile. See “**VA ER/OBSERVATION ALERT**” and “**VA Inpatient Alert**” forms at: www.alaska.va.gov. (Go to Left Hand Menu and Click on Partner Resources, ER/Observation Alert.)

Prescheduled inpatient care is request via the same manner as preauthorized outpatient care (See below Preauthorized Outpatient Care section).

Preauthorized Outpatient Care:

All non-emergent care must be **preauthorized**. VA encourages vendors to submit routine requests and supporting documentation as early as possible in advance.

The process to request preauthorized outpatient care for Non AN/AI Veterans is the same as requesting care for an AN/AI Veteran outside a Native facility. **See AN/AI Referral Management to a Non Native Facility above.** The **Alaska VA Outpatient Authorization Request** form should be submitted.

If an office visit is for an emergent or urgent situation, notify VA by utilizing the ER/Observation Alert Form in order for us to document the encounter within our system as possible ER/urgent care. If coded as emergent care, it will be reviewed as an emergency room visit.

Please read the Authorization Document (VA Form 10-7079) carefully. VA will not be responsible for payment on any follow up appointments, diagnostic testing, or procedures that have not been pre-approved. The patient will be responsible for payment.

All VA rules and regulations pertaining to Veteran benefits, including healthcare, are established by Congress and administered by the Secretary of Veterans Affairs. These rules are subject to change.

Care with Special Eligibility

The VA provides a robust Medical Benefits Package of health services and needs, but some categories/specialties of care do have specific eligibility criteria that must be met in order to receive them. Depending on the enrollment priority group or service connected condition(s) assigned to a Veteran is the determining factor. Special reimbursement rates and eligibility criteria apply to the following services:

- Dental
- Certain Prosthetic items (hearing aids and eyeglasses)
- Long Term Care include nursing home
- Transplant services

Maternity Benefits cover the Veteran's obstetric care in addition to care for the newborn child for the first 7 days.

There are some services that are excluded from the VA Medical Benefits Package which include:

- Cosmetic surgery that is not medically necessary
- Abortions and abortion counseling
- In vitro fertilization
- Drugs, biological and medical devices not approved by the Food and Drug Admin.
- Gender alterations
- Memberships in spas and health clubs

Should there be any questions concerning a Veteran eligibility for any of these services then please contact the Integrated Care Service 1-888-353-7574, ext 6904. Your referral may require a call to another service for verification as well.

Travel Eligibility

Veterans must meet established eligibility criteria for travel related benefits. In order for a Veteran to be eligible for travel benefits they must meet one of the following criteria:

- Veteran must have a service connected disability rating of 30 percent or greater
- Traveling for treatment of a service-connected condition
- Receive a VA pension or income that does not exceed the maximum pension rate. The current rate is \$12,256 with 0 dependents; \$15,493 with 1 dependent; \$18,144 with 2, \$20,237 with 3; \$22,330 with 4; and add \$2,020 for each additional dependent
- Traveling for a scheduled compensation or pension examination

If an AN/AI travel eligible Veteran must drive into a VA/Native facility for treatment and the distance exceeds 27 miles from the facility then they can be reimbursed for their travel. The current mileage reimbursement is 41.5 cents per mile. The Veteran must either present to the Alaska VA travel department for reimbursement, mail in the VA Form 3542, or the form can be faxed to VA travel at 907-257-6774.

Veterans that require air travel for their appointment will need to have the travel request form faxed in to 907-257-6774 to include medical evidence from the facility of the appointment. The VA travel office will validate travel eligibility and notify the Veteran of their travel arrangements. It is requested that the facility be given as much notice as possible (prefer at least two weeks) in order to avoid any delays in arranging travel.

A Veteran may check the status of their travel arrangements by calling the Alaska VA at 907-257-4700, (Option 6 and then Option 1), which will be answered by one of the clerks if available or go to a message line. The travel office will respond to message line calls within 24 hours.

Lodging and meals may also be reimbursable depending on the treatment needed and if an overnight stay is required.

Pharmacy Services

The VA pharmacy provides needed medications accurately, safely, and in a timely manner. They monitor therapeutic outcomes of prescribed medications to minimize potentially negative effects. Prescriptions may be brought in person to the VA Pharmacy window, at 1201 North Muldoon Road, or mailed to the VA Pharmacy at the following address:

**AK VA Healthcare System
Attn: 119 (Pharmacy)
1201 North Muldoon Road
Anchorage, AK 99504
PH: 907-257-4805 or 1-888-353-7574, Extension 4805
FAX: 907-257-6755**

To the extent pharmaceuticals are reimbursable under this Agreement, AVAHS shall reimburse ATHP a dispensing fee at a rate approved by VA's Consolidated Mail Outpatient Pharmacy ("CMOP") for purchases and for the acquisition cost of the drugs at rates equivalent to what AVAHS most recently paid CMOP for the same drug.

AVAHS will routinely reimburse ATHP only for drugs on the formulary used by AVAHS. Requests for reimbursement of non-formulary drugs will be submitted to VA Pharmacy and processed according to AVAHS policy on non-formulary drugs by mail to Alaska VA Healthcare System, Attn: 119 (Pharmacy), Chief, Pharmacy, 1201 North Muldoon Road, Anchorage, Alaska, 99504, telephone 1-800-907-257-4805, or fax 907-257-6755.

AVAHS will reimburse ATHP for drugs provided to an AN/AI Eligible Veteran during an outpatient visit, and for prescriptions filled by ATHP.

Non-AN/AI Eligible Veterans. AVAHS will reimburse ATHP for drugs provided to a non-AN/AI Eligible Veteran during an outpatient visit and for an initial supply that shall not exceed a period of 30 days of prescribed drugs. ATHP shall refer Non-AN/AI Eligible Veterans to a VA facility or CMOP to fill prescriptions other than for the initial 30 day supply. Fax prescription to the VA Pharmacy and the Pharmacist will enter the Veteran in to the CMOP system. The Veteran can bring in the prescription if located in Anchorage and the Pharmacist will enter into the CMOP system for refills. The Veteran can request refills themselves from the CMOP if prescribed by their provider. Most refills for chronic medications are for 90 days.

To obtain a copy of the VA formulary list of medications, please call: 907-257-4805 or 1-888-353-7574, ext. 4805. It is also available at <http://www.pbm.va.gov/NationalFormulary.aspx>

The VA Pharmacy staff is available Monday – Friday, 8:00 am – 4:30 pm.

To file a claim for reimbursement of medications for eligible Native Veterans the information needs to include; Name of Veteran, social security number, date of fill, quantity, generic name, NDC#, tax ID number and provider name. If the drug is a controlled substance the DEA# must also be provided.

Billing/Reimbursement

The bill paying process for Alaska claims are processed in our VA Network Payment Center (NPC) in Vancouver, Washington. You can reach them by calling 855-331-5560 between the hours of 8:30 AM and 3:30 PM (PST), Monday thru Friday.

All claims for services must be submitted electronically or by mail. For electronic claims contact the VA Network Payment Center for setup and contact information.

If you are not already an already established as an authorized VA vendor, please submit your W-9 facility information to the Network Payment Center at fax 306-905-1772 or mail to:

**Network Payment Center -10N20
1601 NE 4th Plain Blvd
Building 17
Vancouver, WA 98661**

Mailed claims are to be sent to:

**Department of Veterans Affairs
Alaska VA Healthcare System
ATTN: Rhonda Munnlyn Fiscal (04) Fee
1201 North Muldoon Road
Anchorage, AK 99504**

Incomplete claims or claims missing information will delay processing and could result in either claim denials or rejects. We process all claims off invoices, not statements. In order to process an invoice in a timely manner, the VA is requesting that each invoice (original not photocopy) UB-04 or CMS 1500 must contain the following:

Claims should contain

- Name, Address, and SSN of the Veteran
- Name, Address, and Tax ID of the Vendor
- Name, Address or facility where services were rendered
- Date of Service
- Detailed itemization, appropriate CPT and/or HCPC codes for each service provided, and ICD-9-CM (diagnosis) code. Payment will be made based on the approved Encounter rate for outpatient visit or inpatient hospitalization as published in the Federal Register. Community Healthy Aide services will be reimbursed at 85% of the Encounter rate.

Claims should be filed within 150 days of the date of service. The VA will make payment on electronic claims within 30 days and 45 days for paper claims.

If Native Health Program seeks reimbursement under the Sharing Agreement, such payment shall be considered payment in full and the Native Health Program may not seek reimbursement for such care from entities or individuals other than VA.

Reimbursement for pharmaceuticals will be made for Native Veterans receiving care by Native Health Organization. Pharmaceuticals for Veterans on an inpatient basis are included in the per diem encounter rate.

Copayment/Third Party Billing

The Co-Payment requirement has been waived for Native Veterans. The Co-payment required for Non-Native Veterans will be determined by VA and the Veteran will be billed by VA.

Co-payment amounts are normally \$15.00 for primary care visit and \$50.00 for a specialty visit. Pharmacy co-payments also required for certain Veterans

VA will pursue third party billing when appropriate for services reimbursed to the Native Health Program.

Common VA Departments and Extensions:

The 1-888 phone numbers below can also be reached by dialing
1-907-257-xxxx (xxxx = extension)
Normal VA Duty Hours: Monday – Friday 8:00 a.m. to 4:30 p.m.

Dental Service	1-888-353-7574, ext. 4940
Diabetes Coordinator	1-888-353-7574, ext. 4828
Inpatient Notification	1-888-353-7574, ext. 4976
Laboratory	1-888-353-7574, ext. 4870
Military Sexual Trauma Coordinator	1-888-353-7574, ext. 4908
My HealtheVet Coordinator	1-888-353-7574, ext. 7496
Outpatient Authorizations for Purchased Care	1-888-353-7574, ext. 6904
Pharmacy	1-888-353-7574, ext. 4805
Prosthetics	1-888-353-7574, ext. 4930
Registration & Eligibility	1-888-353-7574, ext. 3772
Rural Health Program Manager (Ric Epperson)	1-888-353-7574, ext. 5460
Social & Behavioral Health Service	1-888-353-7574, ext. 4854
Suicide Prevention Coordinator	1-888-353-7574, ext. 4846
Telehealth/Triage	1-888-353-7574, Option #2
Veteran Eligibility	1-888-353-7574, Option #6
Veteran Travel	1-888-353-7574, ext. 4738
Veterans Benefits	1-800-827-1000

(For non-healthcare benefits such as Disability and Pension)

Other Alaska Veterans Healthcare Clinics/Offices:

Fairbanks VA Medical Clinic on Ft. Wainwright	1-907-361-6370, Ext #1
Fairbanks RN Care Manager	1-907-361-5878
Patient Services Assistant	1-907-361-5242
Fairbanks VA Toll-Free	1-888-353-5242
Fairbanks Fax	1-907-361-5260
Kenai VA Clinic	1-907-395-4100
Kenai VA Toll-Free	1-877-797-8924
Kenai Fax	1-907-283-4236
Mat-Su VA Clinic	1-907-631-3100
Mat-Su VA Toll Free	1-866-323-8648
Mat-Su VA Fax	1-907-631-3101
Juneau VA Outreach Clinic	1-907-796-4300
Juneau Outreach Toll Free	1-888-308-7890
Juneau Outreach Fax	1-907-796-4301

Phone Numbers for Integrated Care Service

The 1-888 phone numbers below can also be reached by dialing
1-907-257-xxxx (xxxx = extension)

Normal VA Duty Hours: Monday – Friday 8:00 am to 4:30 pm

Authorizations/Outpatient Patient Services Asst. (PSA)	1-888-353-7574, ext 6904
Fax Anchorage Team authorization requests	1-907-257-7479
Fax Rural Team authorization requests	1-907-257-7479
Reconsiderations/Appeals PSA	1-888-353-7574, ext 6929
DeLynn James, Chief, Integrated Care Service	1-888-353-7574, ext 6922
David Marsett, Supervisory Program Specialist	1-888-353-7574, ext 4943
Peggy Balster, Nurse Manager	1-888-353-7574, ext 4819
Cindy Massey, UM Nurse Manager	1-888-353-7574, ext 3740
Inpatient/UM Program Support Asst.	1-907-257-4976
Utilization Management Fax	1-907-257-6920
Karyn Overturf, Oncology Nurse	1-888-353-7574, ext 4767

*Contact either Ms. Stratton or Ms. Brown 1-888-353-7574, ext 5408 or 5448

**Integrated Care Service/Authorizations Message Line 1-888-353-7574, ext 2041

**Messages left on the Message Line are checked daily and returned with 24 hours if required.

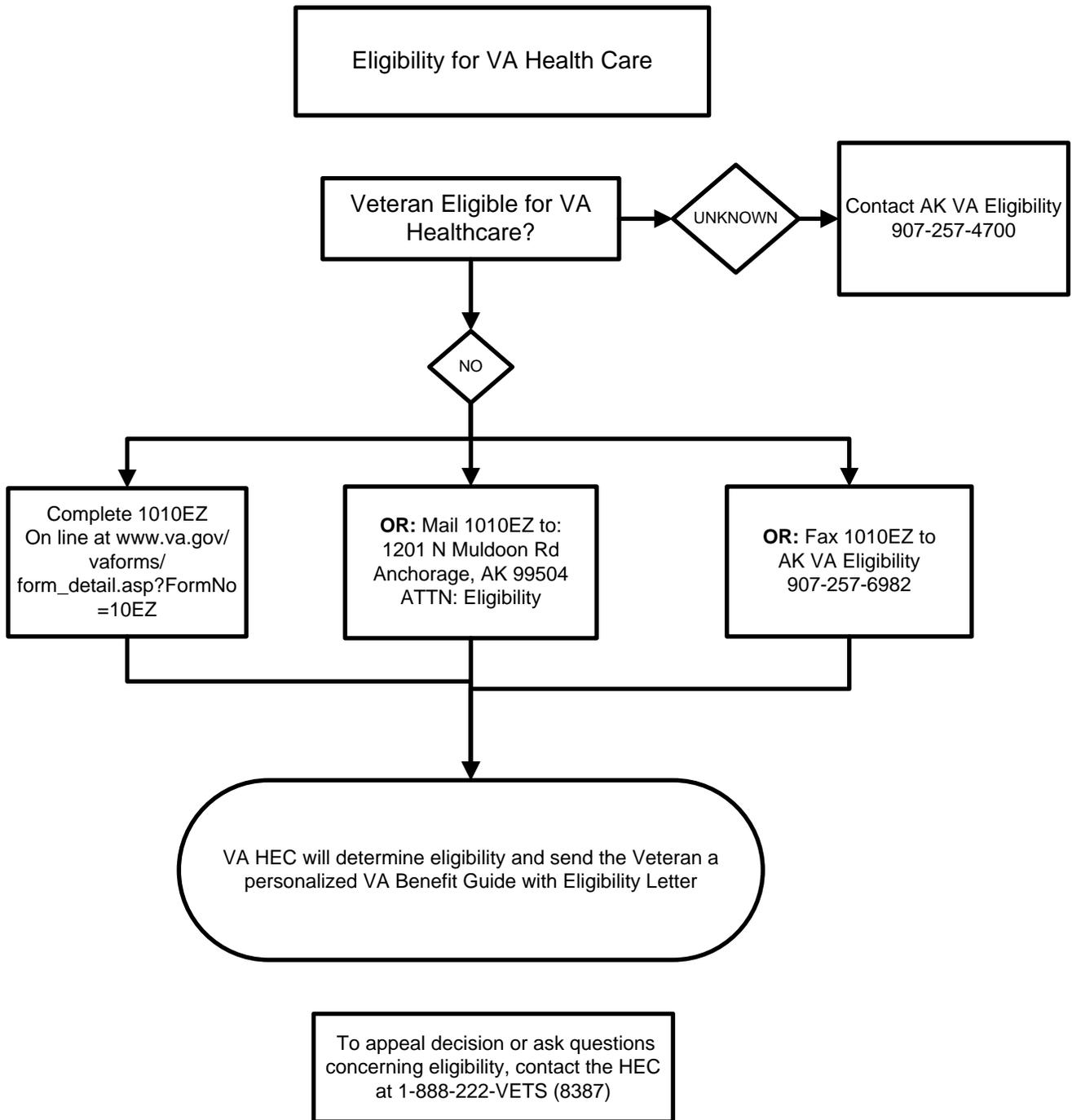
Other Important Numbers to keep handy

Telehealth/Triage (8:00 am–4:00 pm) Veterans' health concerns: 1-888-353-7574, ext 4710

Telehealth/Triage during non-duty hours 24 hr off-site nurses to answer Veterans' health concerns/questions: 1-888-353-7574, option 2

MAAs – “24/7” for emergencies, inpatient admissions, VA transfers, after hour questions (see pages 11-13 for more information) 1-907-580-6420
Toll Free # 1-877-817-3885
MAA Pager 907-580-7243, Ext. #0001

VETERANS CRISIS LINE: 1-800-273-8255, Press 1



 Department of Veterans Affairs		APPLICATION FOR HEALTH BENEFITS		
SECTION I - GENERAL INFORMATION				
Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)				
1. VETERAN'S NAME <i>(Last, First, Middle Name)</i>		2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. WHAT IS YOUR RACE? <i>(You may check more than one.) (Information is required for statistical purposes only.)</i> <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			
7. SOCIAL SECURITY NUMBER	8. VA CLAIM NUMBER	9. DATE OF BIRTH <i>(mm dd/yyyy)</i>		
9A. PLACE OF BIRTH <i>(City and State)</i>		10. RELIGION		
11. PERMANENT ADDRESS <i>(Street)</i>		11A. CITY	11B. STATE	11C. ZIP CODE
11D. COUNTY	11E. HOME TELEPHONE NUMBER <i>(Include area code)</i>		11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER <i>(Include area code)</i>		12. TYPE OF BENEFIT(S) APPLYING FOR <i>(You may check more than one)</i> <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL		
13. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? <i>(for listing of facilities visit www.va.gov/directory)</i>		14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.		
15. CURRENT MARITAL STATUS <i>(Check one)</i> <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN				
16. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN		16A. NEXT OF KIN'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
		16B. NEXT OF KIN'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		
17. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT <i>(if different than 16)</i>		17A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER <i>(Include area code)</i>		
		17B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER <i>(Include area code)</i>		
SECTION II - INSURANCE INFORMATION <i>(Use a separate sheet for additional information)</i>				
1. ENTER HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER <i>(include coverage through spouse or other person)</i>				
2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	5A. EFFECTIVE DATE <i>(mm dd/yyyy)</i>
6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO		6A. EFFECTIVE DATE <i>(mm dd/yyyy)</i>		
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? <input type="checkbox"/> YES <input type="checkbox"/> NO		7A. EFFECTIVE DATE <i>(mm dd/yyyy)</i>		
8. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		9. MEDICARE CLAIM NUMBER		

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME (<i>Last, First, Middle</i>)		SOCIAL SECURITY NUMBER	
SECTION III - EMPLOYMENT INFORMATION					
1. VETERAN'S EMPLOYMENT STATUS (<i>Check one</i>) <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED If employed or retired, complete item 1A <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>			1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
2. SPOUSE'S EMPLOYMENT STATUS (<i>Check one</i>) <input type="checkbox"/> FULL TIME <input type="checkbox"/> NOT EMPLOYED If employed or retired, complete item 2A <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <i>Date of retirement (mm/dd/yyyy)</i>			2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER		
SECTION IV - MILITARY SERVICE INFORMATION					
1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER	
2. CHECK YES OR NO		YES	NO		
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?		<input type="checkbox"/>	<input type="checkbox"/>	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	
B. ARE YOU A FORMER PRISONER OF WAR?		<input type="checkbox"/>	<input type="checkbox"/>	F. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	
C. DID YOU SERVE IN COMBAT AFTER 11/11/1998?		<input type="checkbox"/>	<input type="checkbox"/>	G. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	
D. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?		<input type="checkbox"/>	<input type="checkbox"/>	H. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	
D1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?		<input type="checkbox"/>	<input type="checkbox"/>	I. DO YOU HAVE A SPINAL CORD INJURY?	
SECTION V - FINANCIAL DISCLOSURE					
Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. Recent Combat Veterans are eligible for enrollment without disclosing their financial information but like other Veterans may provide it to establish their eligibility for travel assistance, cost-free medication and/or medical care for services unrelated to military experience.					
<input type="checkbox"/> No, I do not wish to provide financial information in Sections VI through IX. I understand that VA is not enrolling new applicants who do not provide this information and who do not have other qualifying eligibility factors [i.e., a former Prisoner of War; in receipt of a Purple Heart; a recently discharged Combat Veteran (e.g., OEF/OIF/OND who were discharged within the past 5 years); discharged for a disability incurred or aggravated in the line of duty; receiving VA service-connected disability compensation; receiving VA pension; or in receipt of Medicaid benefits.] <i>Sign and date the form in Section XII.</i>					
<input type="checkbox"/> Yes, I will provide my household financial information for last calendar year. Complete applicable sections VI through IX. <i>Sign and date the form in Section XII.</i>					
SECTION VI - DEPENDENT INFORMATION (Use a separate sheet for additional dependents)					
1. SPOUSE'S NAME (<i>Last, First, Middle Name</i>)			2. CHILD'S NAME (<i>Last, First, Middle Name</i>)		
1A. SPOUSE'S MAIDEN NAME OR OTHER NAMES USED			2A. CHILD'S RELATIONSHIP TO YOU (<i>Check one</i>) <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
1B. SPOUSE'S SOCIAL SECURITY NUMBER			2B. CHILD'S SOCIAL SECURITY NUMBER	2C. DATE CHILD BECAME YOUR DEPENDENT (<i>mm/dd/yyyy</i>)	
1C. SPOUSE'S DATE OF BIRTH (<i>mm/dd/yyyy</i>)	1D. DATE OF MARRIAGE (<i>mm/dd/yyyy</i>)		2D. CHILD'S DATE OF BIRTH (<i>mm/dd/yyyy</i>)		
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER (<i>Street, City, State, ZIP - if different from Veteran's</i>)			2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? <input type="checkbox"/> YES <input type="checkbox"/> NO		
			2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO			2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (<i>e.g., tuition, books, materials</i>) \$		

APPLICATION FOR HEALTH BENEFITS, Continued		VETERAN'S NAME (<i>Last, First, Middle</i>)		SOCIAL SECURITY NUMBER	
SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN (Use a separate sheet for additional dependents)					
	VETERAN	SPOUSE	CHILD 1		
1. GROSS ANNUAL INCOME FROM EMPLOYMENT (<i>wages, bonuses, tips, etc.</i>) EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$		
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$		
3. LIST OTHER INCOME AMOUNTS (<i>e.g., Social Security, compensation, pension interest, dividends</i>). EXCLUDING WELFARE.	\$	\$	\$		
SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES					
1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (<i>e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home</i>) VA will calculate a deductible and the net medical expenses you may claim.				\$	
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (<i>Also enter spouse or child's information in Section VI.</i>)				\$	
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (<i>e.g., tuition, books, fees, materials</i>) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.				\$	
SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)					
	VETERAN	SPOUSE	CHILD 1		
1. CASH AMOUNT IN BANK ACCOUNTS (<i>e.g., checking, savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds</i>)	\$	\$	\$		
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. (<i>e.g., second home and non-income producing property. Do not count your primary home.</i>)	\$	\$	\$		
3. VALUE OF OTHER PROPERTY OR ASSETS (<i>e.g., art, rare coins, collectables</i>) MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. <i>Exclude household effects and family vehicles.</i>	\$	\$	\$		
SECTION X - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION					
<p>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 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.</p> <p>Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified 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 delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also 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.</p>					
SECTION XI - CONSENT TO COPAYS					
By signing this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law.					
SECTION XII - ASSIGNMENT OF BENEFITS					
<p>I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.</p>					
ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.					
SIGNATURE OF APPLICANT				DATE	



Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system, or dental benefits. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 45 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at <http://www.va.gov> and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started:

ALL VETERANS MUST COMPLETE SECTIONS I - IV.

Directions for Sections I - IV:

Section I - General Information: Answer all questions. **Note:** *Veterans determined by a VA clinician to be Catastrophically Disabled are enrolled in Priority Group 4, unless eligible for a higher Priority Group, and are exempt from inpatient, outpatient and prescription copays. However, these Veterans may still be subject to copayments for extended care (long-term) services.*

Section II - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Section III - Employment Information: If you are employed or retired, answer all questions.

Section IV - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Directions for Sections V - IX:

Section V - Financial Disclosure: ONLY NSC and 0% NONCOMPENSABLE SERVICE-CONNECTED VETERANS WHO ARE NOT:

- a former Prisoner of War or;
- in receipt of a Purple Heart or;
- a recently discharged Combat Veteran or;
- discharged for a disability incurred or aggravated in the line of duty or;
- receiving VA service-connected disability compensation or;
- receiving VA pension or;
- in receipt of Medicaid benefits or;
- determined by VA to be Catastrophically Disabled

MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY AND COPAY RESPONSIBILITY FOR VA health care enrollment and/or care or services. *Failure to provide financial information, if required to do so, may result in denial of VA health care enrollment.*

Continued ...

Section VI - Dependent Information: Your spouse and dependent social security number(s) are required so we can verify their financial and insurance information through a computer-matching program.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children: Answer applicable questions

Section VIII - Previous Calendar Year Deductible Expenses: Answer applicable questions

Section IX - Previous Calendar Year Net Worth: Answer applicable questions

NOTE: All other Veterans may wish to provide this financial assessment to determine, **as applicable**, their eligibility for cost-free medication for their NSC conditions, beneficiary travel eligibility and/or waiver of the beneficiary travel deductible requirement.

Additional Information for Completing your application ...

Answer all questions in the appropriate sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. If you need more room to respond to a question, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information.

Include information for all health insurance policies that cover you, this includes coverage that is provided through a spouse or significant other. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - Military Service Information.

If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.

If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your Purple Heart status, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating your award. To reduce processing time, you may submit a copy of this documentation with your application.

Section V - Financial Disclosure.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information and agree to make co-payments for treatment of your NSC conditions. If a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of deductible, and you do not disclose your financial information, you may not be eligible for these benefits.

Section VI - Dependent Information - Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Continued ...

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payment; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VIII - Previous Calendar Year Deductible Expenses.

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report expenses of last illness and burial expenses, e.g., prepaid burial, paid by the veteran for spouse or dependent(s).

Section IX - Previous Calendar Net Worth.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

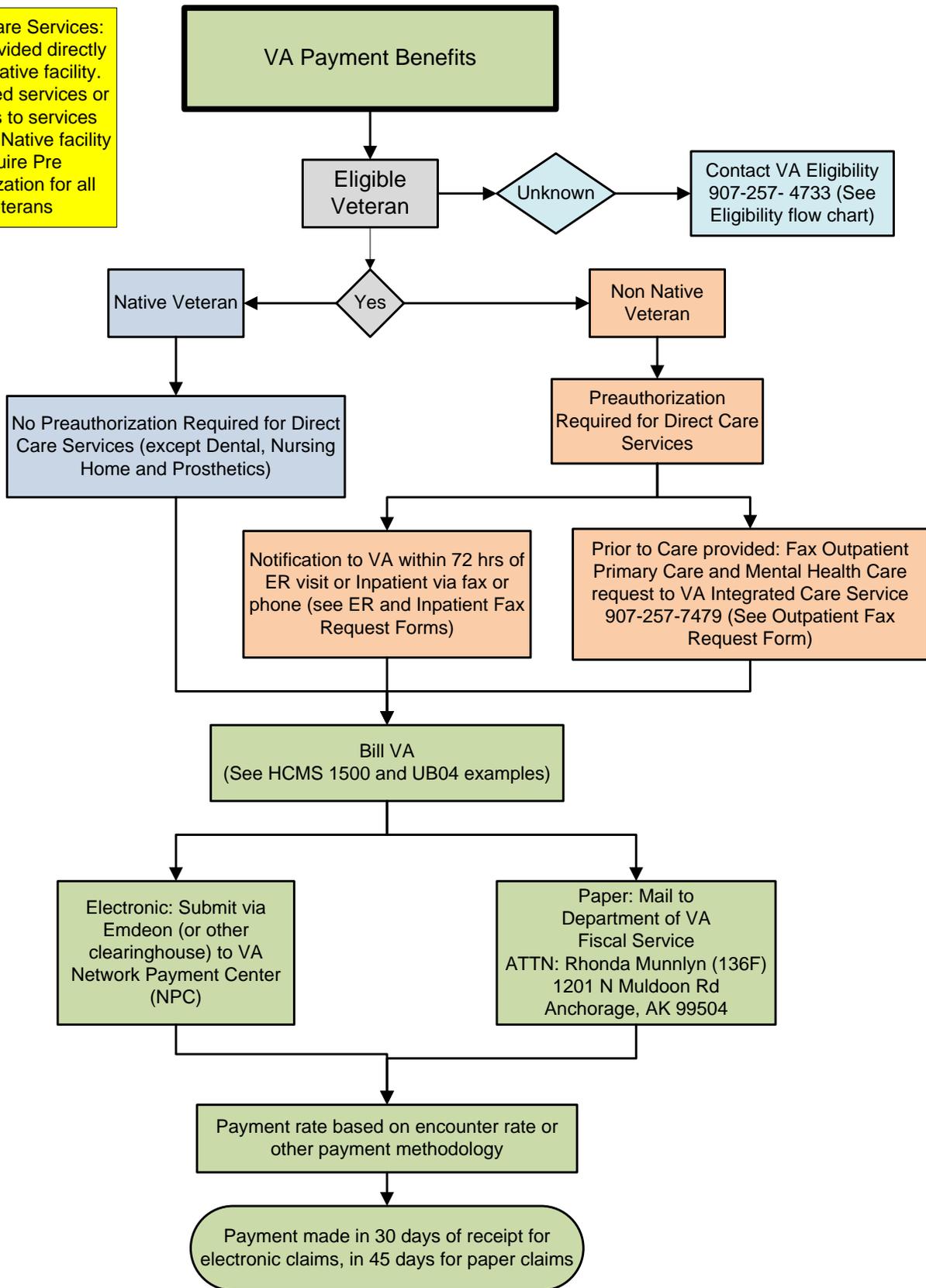
Submitting your application.

1. Read Section X, Paperwork Reduction and Privacy Act Information, Section XI Consent to Copays and Section XII, Assignment of Benefits.
2. In Section XII, you or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
3. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to your local VA health care facility. You can find the address by calling VA at 1-877-222-VETS (8387), or on the Internet at <http://www.va.gov>.

Direct Care Services: Care provided directly by the Native facility. Contracted services or referrals to services outside a Native facility require Pre Authorization for all Veterans





ALASKA VA OUTPATIENT

AUTHORIZATION REQUEST

Phone: 257-6904 or 1-888-353-7574 ext. 6904

NOTES MUST ACCOMPANY THIS REQUEST

Fax: 907-257-7479

Today's Date: _____

Vendor's Name: _____

Ordering Provider's Name: _____

Vendor's Address: _____

Vendor's Phone: _____ Fax: _____ Tax Id: _____

Veteran's Name: _____ SSN: _____

Diagnosis: _____

Desired treatment, procedure, or referral: _____

Lab _____ X-ray _____ Rx _____ Other _____

Date of desired treatment, procedure, or referral: _____

Location of treatment if different from doctor's office: _____

Period of Care: Yes _____ No _____ (Indicate length of time and number of visits)

Surgical Procedure: Yes _____ No _____ (If yes, list CPT codes with cost estimates & ancillaries)

Comments: _____



ALASKA VA INPATIENT ALERT

Please attach a copy of Admission Face Sheet with this Alert.
(VA INPATIENT FAX: 1-907-257-6920)

Today's Date: _____
Hospital Name: _____
Hospital FAX: _____
Admitting Physician: _____
Admission Type: ER____ Direct____ Scheduled____
Date Patient in ER if different than admit date: _____
Patient Unstable for Transfer: _____ (Initials Please)
Date Of Admission: _____ Date of Discharge: _____
Veteran's Name: _____ SSN: _____
Diagnosis: _____
Specialty: Med____ Surg____ Psych____ Rehab____ OB____
Additional Insurance Information: _____

***** VETERAN'S STATEMENT: I request VA coverage for this episode of care. In accordance with the law, I understand I am subject to transfer to a federal facility.**

Signature of veteran or family member: _____

(Please, do not write below this line, for VA use only)

AUTHORIZED: _____ NOT AUTHORIZED: _____



ALASKA VA
EMERGENCY ROOM/OBSERVATION ALERT
(VA ER FAX: 1-907-257-7479 or Toll Free 1-888-883-0574)

TODAY'S DATE: _____

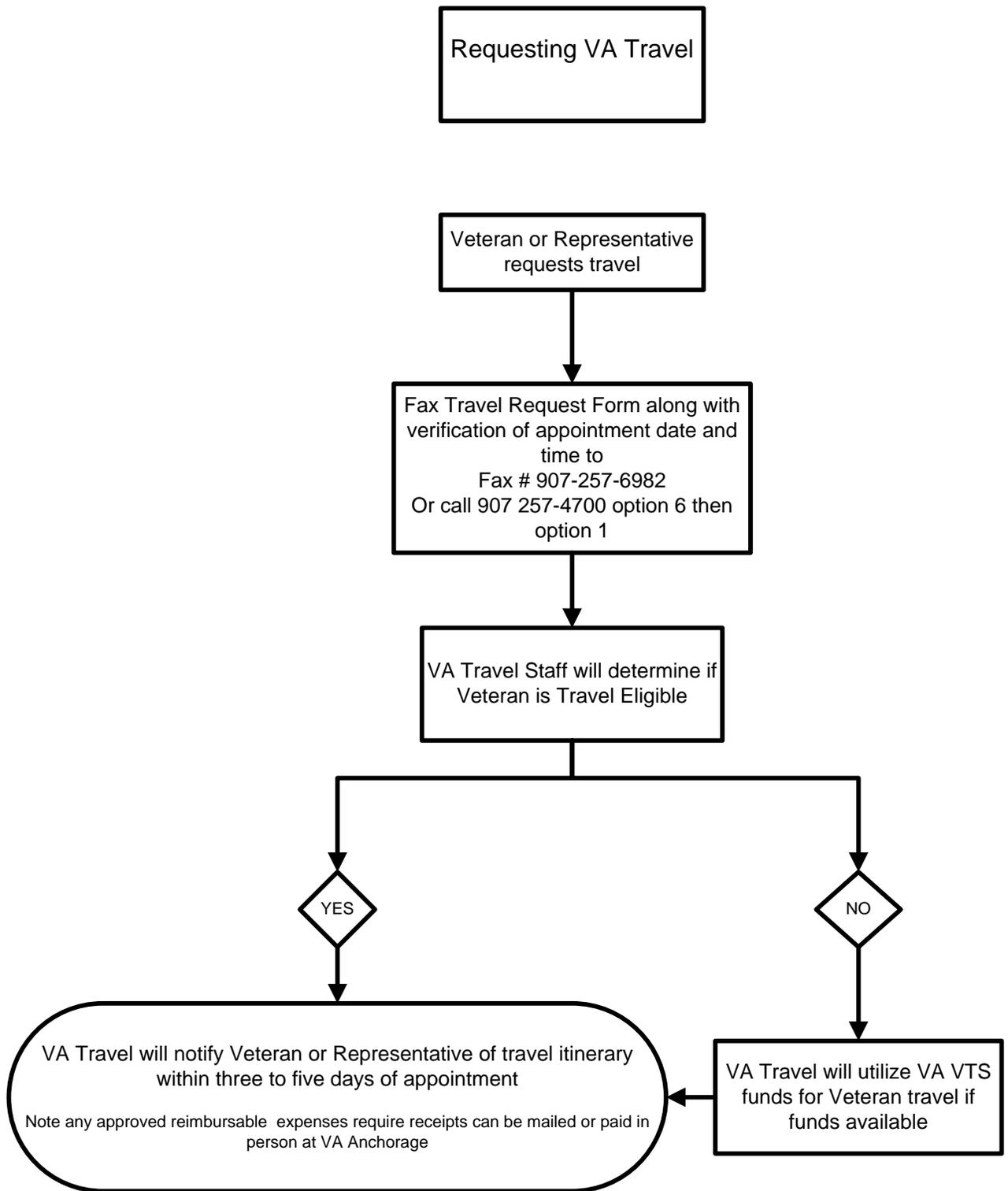
HOSPITAL NAME: _____

HOSPITAL FAX: _____

DATE OF SERVICE: _____

VETERAN'S NAME: _____ SSN: _____

DIAGNOSIS: _____



VA TRAVEL REQUEST FORM

Requesting Facility Information

Name of Facility: _____ Request Date: _____
 Name of Requesting Official: _____
 Contact Phone: (____) ____ - _____
 Email Address: _____

Patient Information

Veteran's Last Name: _____ Veteran's First Name: _____
 Last 4 of Veteran's Social Security Number: _____
 Permanent Address: _____
 Temporary Address (if applicable): _____
 Home Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____
 Select Specialty: MED ____ SURG ____ PSYCH ____
 Appointment Date and Time: _____
 Facility of Appointment: _____ City: _____
 Will patient need an escort? Yes or No Name of escort: _____

Please complete escort request form.

Travel Information

Date of Travel (mm/dd/yyyy)	FROM (Departure Location)	TO (Arrival Location)	Mode of Travel A = Air S = Sea T = Train G = Ground Transport

FOR BENEFICIARY TRAVEL CLERK ONLY

Received Date: _____	Is veteran eligible for travel benefits? (circle one): Yes No	
	Is veteran eligible for VTS? (circle one): Yes No	
Date contacted veteran	Contacted by	Comments

Travel Office: 888-353-7574 Option 6, Option 1

Fax: 907-257-6982

Special Travel Request

TO: BENEFICIARY TRAVEL OFFICE

PATIENT: _____

NEEDS A NON-MEDICAL ESCORT DUE TO THE FOLLOWING:

_____ DEMENTIA/MEMORY LOSS

_____ BLIND

_____ UNABLE TO TRANSFER SELF FROM WHEELCHAIR

_____ NEED FOR OIST-OP ATTENDANCE

NEEDS A FLIGHT INSTEAD OF DRIVING DUE TO THE FOLLOWING:

_____ DOCUMENTED CHRONIC BACK PAIN

_____ UNABLE TO DRIVE DUE TO THE FOLLOWING MEDICATIONS:

_____ SEVERE ANXIETY/PTSD

_____ INSOMNIA (HIGH RISK DRIVER)

_____ KNEES/LEG DISABILITY – (SPECIFIC PROBLEM) _____

_____ VISION/HEARING DIFFICULTIES

_____ TRAUMATIC ARTHRITIS

_____ CANNOT SIT FOR EXTENDED PERIODS OF TIME due to: _____

_____ OTHER: _____

**THIS IS AUTHORIZED BY THE MEDICAL PROVIDER LISTED BELOW:
And subject to review by Chief of Staff**

EFFECTIVE DATE: _____
(THIS REQUEST IS VALID FOR 1 YEAR FROM THE DATE SIGNED)

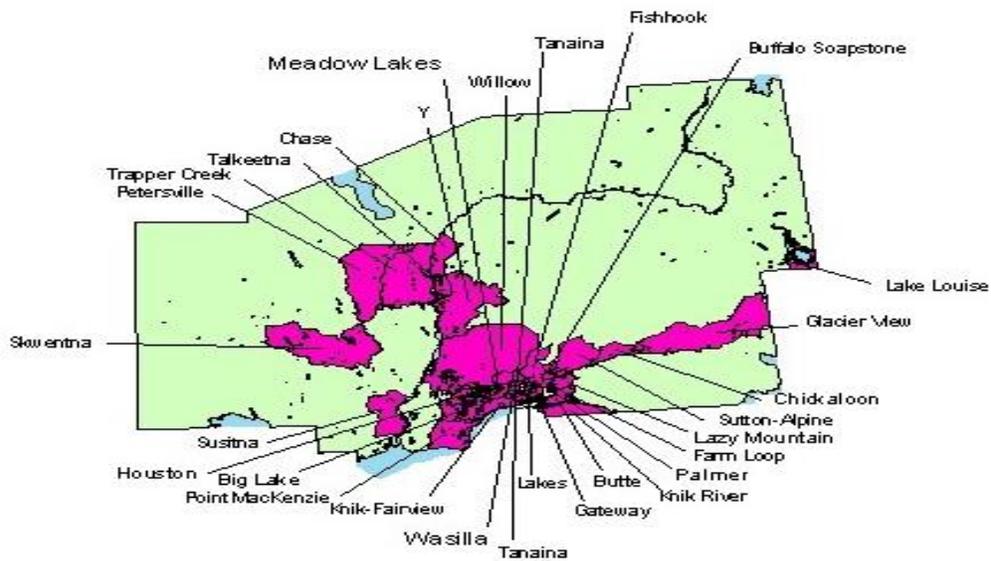
Anchorage VA Outpatient Clinic Catchment Area

Anchorage Borough



MatSu CBOC Clinic Catchment Area

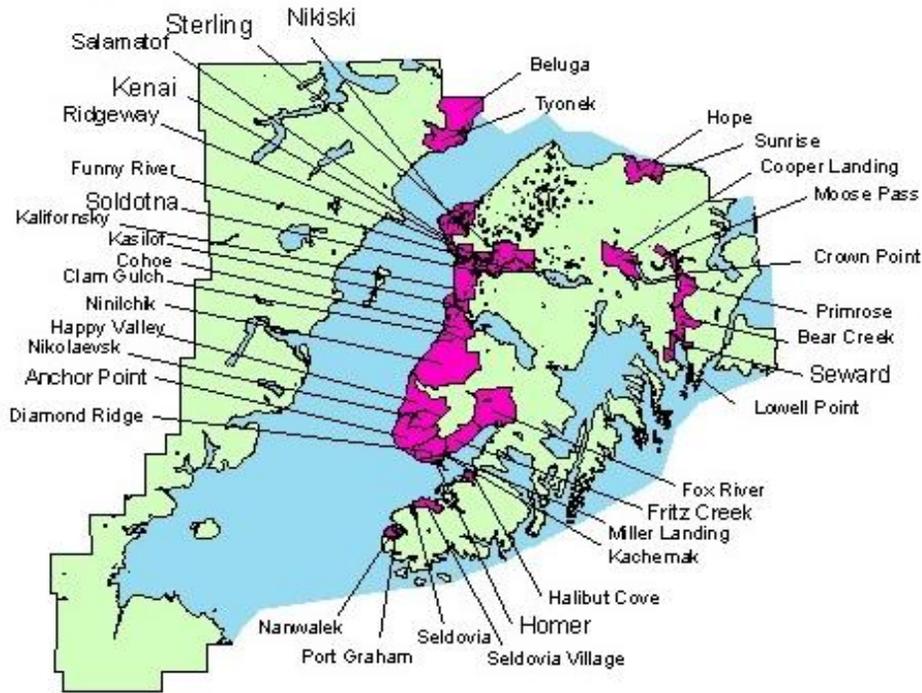
Matanuska-Susitna Borough



Kenai CBOC and Homer Outreach Clinic Catchment Area



Kenai Peninsula Borough



Juneau Outreach Clinic Catchment Area



Juneau Borough

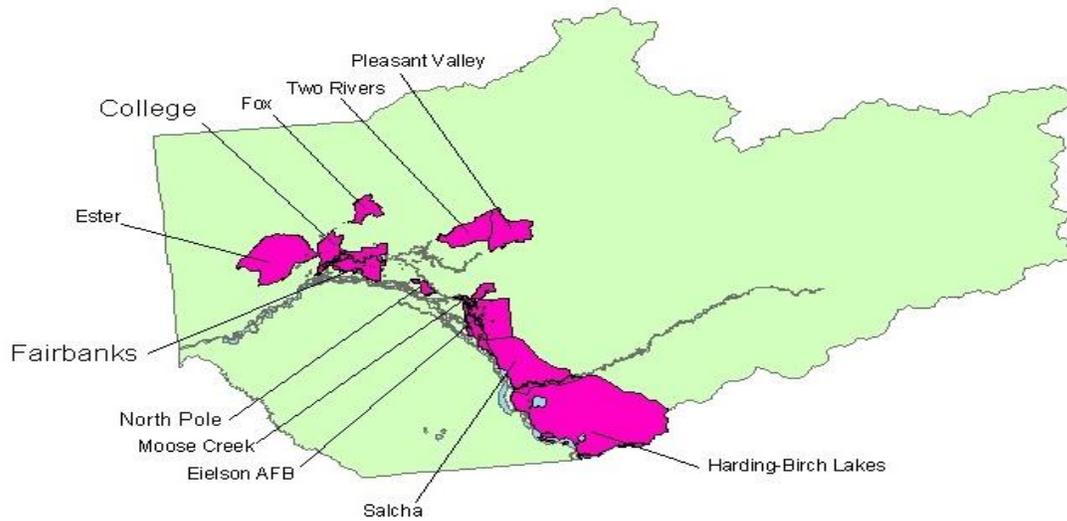
Juneau, Auk Bay, Douglas



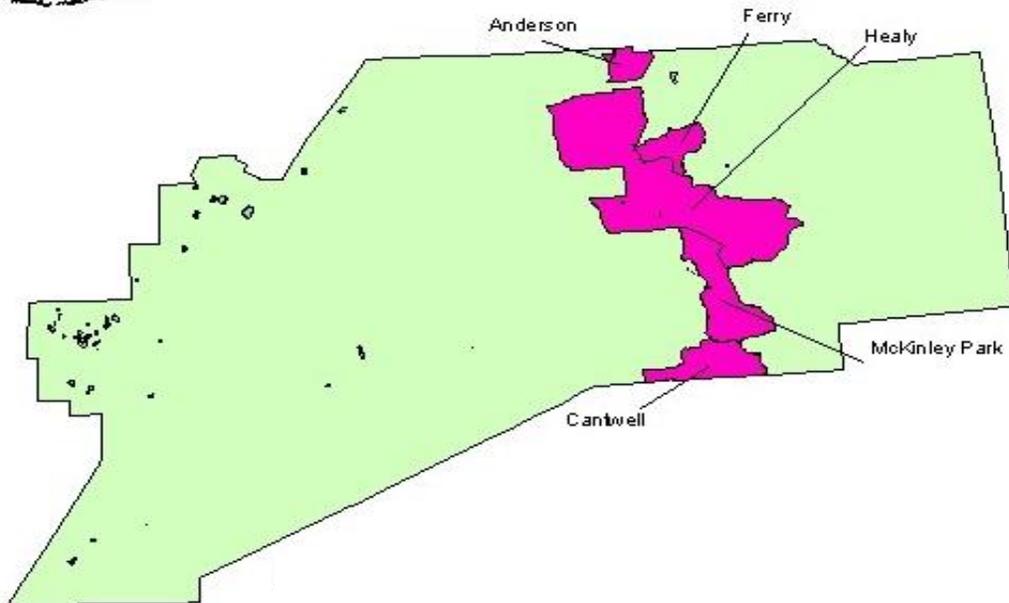
Fairbanks CBOC Catchment Areas



Fairbanks North Star Borough



Denali Borough



Fairbanks CBOC Catchment Areas - continued



Southeast Fairbanks Census Area

