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ICE Health Service Corps

Medical Payment Authorization Request Form

Send paper claims to:
ICE Health Service Corps
VA Financial Services Center
PO Box 149345
Austin, TX 78714-9345

For EDI claim submission information and claim inquires, please contact 1.800.479.0523

For proper provider claim submission information, please visit: www.icehealth.org/ManagedCare/Providers.shtm

Medical, mental health and dental services will not be paid without an approved payment authorization on file. Services rendered may not be paid without an approved authorization. All payment for services is made in accordance with US Code Title 18, Part 3, Chapter 301, Sec. 4006. All claims are subject to retrospective review. For further information regarding IHSC, please visit our website: www.icehealth.org or contact the ICE Health Service Corps Managed Care Branch M-F 0800 to 1630 EST.

Please ensure all claims include the Patient Identification Information and the Authorization number.

Authorized Action:

Auth #: _____ Approving Official: _____

Service Type: _____ Referral Type: _____

To: (Provider or Hospital Name and Phone Providing Services) _____

Dialogue of Request:

_____
_____
_____
_____
_____
_____

List Procedure(s), Test(s), Service(s) or Supplies:

_____
_____

Provider's Certification of Serious Medical Need

I, _____ ,
(Name of Provider)

certify that this (these) procedures, tests, services and/or supplies is medically appropriate treatment in response to a serious medical need(s). Serious medical needs are those conditions which, if left untreated, could result in further significant injury or the unnecessary and unwanted infliction of pain. Serious medical needs include conditions that affect daily activities or which cause chronic and substantial pain.

Detainee Information

Name:	Alias:
DOB:	A#:
Nationality:	Facility:

ICE Health Service Corps

Medical Payment Authorization Request Form (Continued)

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable laws.

1. A copy of this form should be provided by the detention facility to the referred facility or provider. Payment is subject to custody verification.
2. All services determined by the detainee's medical provider to be medically necessary and appropriate are covered except for experimental and investigative services and cosmetic services and procedures that are not medically justified.
3. The health care provider or facility administering treatment will maintain records to fully disclose the extent of services provided to individuals and to furnish information regarding any payments claimed for providing such services as the U.S. Immigration and Customs Enforcement may request.
4. All payment for services is considered payment in full to the health care provider or health care facility and made in accordance with US Code Title 18, Part 3, Chapter 301, Sec. 4006.
5. IHSC is to be notified of all emergency and hospital admissions for tracking and case management purposes.

Consultation Report:

Detainee Information

Name:	Alias:
DOB:	A#:
Nationality:	Facility: