TRICARE PATIENT REFERRAL/AUTHORIZATION FORM

Use this form for Medical/Surgical Requests Only

Sponsor SSN _____ Sponsor Name _____

Patient Name _____ Patient SSN _____

Address _____ Date of Birth _____

City _____ State _____ Zip Code _____

Home Telephone (_____) _____ Patient's Relationship to Sponsor _____

Requesting Provider _____ Contact Name _____

TIN _____ NPI _____ (NPI Optional)

Address _____

City _____ State _____ Zip Code _____

Telephone (_____) _____ Fax (_____) _____

ICD-9 _____ Diagnosis _____

Inpatient _____ Outpatient Facility _____ Home _____ Office _____ (Select One)

Emergency _____ Routine _____ Urgent _____ (Select One)

Servicing Provider/Specialty _____

TIN _____ NPI _____ (NPI Optional)

Address _____

City _____ State_____ Zip Code _____

Telephone (_____) _____ Fax (_____) _____

Facility _____

TIN _____ NPI _____ (NPI Optional)

Telephone (_____) _____ Fax (_____) _____

Requested Service _____

_____

CPT4/HCPCS Code(s) (list all and include NDC codes for medication requests). _____

_____

Date of Service _____ Number of Visits _____

Attach clinical notes, appropriate lab results, H&P and other information to support the medical necessity for the requested service. If this is a DME request, attach an itemized list of codes and costs.
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.

Prime/Standard – Fax 866-269-5892
TRICARE Prime Remote, TRICARE Reserve Select – Fax 866-312-5831
Hospice, Transplant, and Cancer Clinical Trials – Fax 866-269-5758
Continued Health Care Benefit Program (CHCBP) is administered by Humana – Call 800-444-5445
TRICARE for Life is administered by WPS – Call 866-773-0404

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.