TRICARE For Life Authorization Request
Skilled Nursing Facility

TRICARE

WPS HEALTH INSURANCE

PLEASE RETURN COMPLETED FORM TO:
TRICARE For Life/WPS
c/o Medical Review Department
1707 W. Broadway • P.O. Box 7934 • Madison, WI 53713
Fax: (608) 301-3226

OR

Submit by email to:
SNFauthorizations@wpsic.com
OR
Submit online at www.TRICARE4u.com
Log into the secured messaging section of TRICARE4u.com to submit your authorization request.

See Page 2 for instructions to complete this form.

Requesting Provider Information

Service Provider/Facility Name: _____ *

Contact Name: _____ *

Provider Fax Number: _____ * Billing Tax ID: _____ *

Provider Telephone Number: _____ Ext: _____ *

Email Address: _____ *

Servicing Provider/Facility Address: _____ *

_____

***required fields**

Patient Information (please complete all fields)

TRICARE Benefit ID/Sponsor Number: _____ * Patient date of birth (mm/dd/yyyy): _____ *

Patient Name (Last, First, MI): _____ *

Patient Address: _____

_____

_____

***required fields**

Patient Information (please complete all fields)

******Authorizations need to be obtained prior to the start of service******

3 Day Qualifying Hospital Stay Dates (mm/dd/yyyy): _____ *

Medicare/Other Insurance Exhaust Date (mm/dd/yyyy): _____ *

Start Date for TRICARE Authorization (mm/dd/yyyy): _____ *

Estimated Length of Stay in Days: _____ *

Diagnosis Code: _____ * Description: _____

Diagnosis Code: _____ * Description: _____

***required fields**

The following information must be included to help eliminate delays in processing your request:

History and Physical (H&P) from Hospital
Discharge Summary from recent acute care stay
MD orders - last 4 weeks
MDS (most recent)
MD progress notes - last 4 weeks
Nurses Notes - last 4 weeks
Wound care: measurement, treatment, where acquired
PT evaluations/logs/progress notes
OT evaluations/logs/progress notes
ST evaluations/logs/progress notes
RT documentation

This form needs to accompany ALL records/correspondence.

Skilled Nursing Facility Request Form

Requesting Provider Information: *Complete all fields.*

- **Servicing Provider/Facility Name:** Enter the name of the individual provider who will be performing the services. If there is no individual provider enter the name of the facility where services are taking place.
- **Contact Name:** Enter the name of the person to contact for questions or requests for additional information regarding the authorization request.
- **Billing Tax ID or NPI:** Enter the billing Tax ID of the service provider or facility.
- **Provider Telephone Number/Ext:** Enter the contact telephone number and extension (if applicable).
- **Provider Fax Number:** Enter the contact fax number.
- **Email Address:** Enter the contact email address.
- **Provider/Facility Address:** Enter the street address, city, state and zip code of the service provider or facility where the services will take place.

Patient Information: *Complete all fields.*

- **TRICARE Benefit ID/Sponsor Number:** Enter the policy number/plan number/sponsor number under which the patient is eligible for TRICARE benefits.
- **Patient Date of Birth:** Enter the date of birth of the patient (format: mm/dd/yyyy).
- **Patient Name:** Enter the name of the patient.
- **Patient Address:** Enter the patient's street address.

Requested Service Information: *Complete all fields.*

- **3 Day Qualifying Hospital Stay Dates:** Enter the qualifying hospital stay dates (format: mm/dd/yyyy - mm/dd/yyyy).
- **Medicare/Other Insurance Exhaust Date:** Enter the date Medicare/Other Insurance skilled nursing benefit coverage exhausts (format: mm/dd/yyyy).
- **Start Date for TRICARE Authorization:** Enter the start date of the TRICARE authorization (format: mm/dd/yyyy).
- **Estimated Length of Stay in Days:** Enter the estimated number of days patient will stay in skilled nursing facility care. Request can be for no more than 30 days maximum.

Required Medical Documentation *Include the following documentation with all SNF authorization requests.*

History and Physical (H&P) from Hospital.
Discharge summary from recent acute care stay.
MD Orders - last 4 weeks
MD Progress Notes - last 4 weeks
Most recent Minimum Date Set (MDS) assessment.
Nurses' Notes - last 4 weeks
Wound Care: measurement, treatment, where acquired (e.g. at SNF, at hospital, in community).
Physical Therapy evaluations, logs, progress notes.
Occupational Therapy evaluations, logs, progress notes.
Speech Therapy evaluations, logs, progress notes.
Respiratory Therapy documentation.

**TRICARE For Life only issues authorizations when TRICARE For Life is the primary payer, and when TRICARE policy requires an authorization for the service. TRICARE For Life does not issue retroactive authorizations for any reason. Medically necessary services are payable in the absence of an authorization by this process: Submit a claim with attached medical documentation through your established new claim submission process.

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