UnitedHealthcare®
MILITARY & VETERANS

TRICARE Service Request/Notification

Fax referral to: UnitedHealthcare Military & Veterans at:
877-890-9309 Routine
877-890-8203 Urgent

The Military Treatment Facility (MTF) in your area may have Right of First Refusal for this service.

Beneficiary Information					
Name: Last	First	M.I.	Gender	DOB: (mm/dd/yyyy) ____ / ____ / ______	
Address: Street	Apt. No.	City		State	ZIP Code
Contact Phone #:		Sponsor SSN:			
Requesting Provider Information					
Name:				NPI #:	
Address: Street		City		State	ZIP Code
Contact Name: Last	First			Contact's Department in Facility:	
Office Phone #:		Office Fax #:			
Provider Rendering Care (Physician/Facility/Agency/Vendor)					
Name: (Physician/Facility/Agency/Vendor)				Provider NPI #: (mandatory on form)	
Specialty:		Sub-specialty: (if applicable)			
Reason for Sub-specialty Request:		Anticipated Date of Service/Admission Date: (mm/dd/yyyy) ____ / ____ / ______			
Address: Street		City		State	ZIP Code
Office Phone #:		Office Fax #:			
Servicing Facility Information					
Name:				TIN:	
Address: Street		City		State	ZIP Code
Request Priority: (Please check one) ☐ Routine ☐ Urgent					
Service Type: (Please check one) ☐ Specialty Referral ☐ Inpatient (Acute, SNF, RTC or Rehab) ☐ Outpatient (Medical/Surgical or Behavioral Health) ☐ DME, Home health					

This document may contain personally identifiable information, including protected health information. Only those with a need to know should access or use this document. Access, use or disclosure of this document or its contents must comply with the MHS Notice of Privacy Practices, the HIPAA Privacy Rule and the DoD Privacy Program. If you received this document in error, please contact us immediately at 1-877-988-9378.

TRICARE West Region Customer Service: 1-877-988-9378 (WEST) ▪ www.uhcmilitarywest.com

TRICARE is a registered trademark of the TRICARE Management Activity. All rights reserved.

© 2013 United HealthCare Services, Inc.

UnitedHealthcare®
MILITARY & VETERANS

TRICARE Service Request/Notification

Admission Type: (Please check one) ☐ ER ☐ Direct Admit ☐ Elective

Diagnostic Information		
	Diagnosis:	ICD-9 Code:
	Any Secondary Diagnosis:	ICD-9 Code:
	Requested Procedures/Services:	CPT 4 Code/ HCPCS Code:
	Frequency Requested: _____ ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	
	Duration: ______ ☐ Days ☐ Weeks ☐ Months	
	Number of Visits Requested:	
	If DME: ☐ Purchase ☐ Rental	
Medical Necessity of Services (Reason for request and/or Explanation of Medical Necessity)		

This document may contain personally identifiable information, including protected health information. Only those with a need to know should access or use this document. Access, use or disclosure of this document or its contents must comply with the MHS Notice of Privacy Practices, the HIPAA Privacy Rule and the DoD Privacy Program. If you received this document in error, please contact us immediately at 1-877-988-9378.

TRICARE is a registered trademark of the TRICARE Management Activity. All rights reserved.

© 2013 United HealthCare Services, Inc.