

# TRICARE Referrals and Prior Authorizations



## Submitting Referral and Authorization Requests

### Referral and Prior Authorization Guidelines

Request a referral or authorization for using the online referral and authorization submission tool, located within the secure provider portal at [www.triwest.com/provider](http://www.triwest.com/provider) or by faxing a *TRICARE Patient Referral/Authorization Form* to TriWest.

**To submit your referrals and authorizations online, the following requirements must be met:**

- You have to be a registered user on the secure provider portal at [www.triwest.com/provider](http://www.triwest.com/provider).
- You should take the online tutorial to learn how to use the online referral tool or refer to the *User's Guide* on the secure provider portal.

**Important points to understand before entering your referrals and authorizations online:**

- Always enter a reason and/or clinical information to support your request. This is important information to send the servicing provider and/or the military treatment facility (MTF). Not providing this information can delay the completion of your request.
- Only office visits, outpatient care, and preadmission requests can be entered online. Inpatient admission notification may not be entered online. You must fax inpatient notifications to TriWest.
- If you are not the beneficiary's primary care manager (PCM) or an ordering practitioner, identify the referring provider in the note field. You should not request services outside your scope of practice.

If you experience any issues or need help with the online submission tool, click the "Technical Assistance with Submission Requests" link and complete the online form. This form will go directly to your TriWest Support Team and someone will contact you shortly. This is only for obtaining assistance with tool functionality and not for resolving referral or authorization issues, which are usually handled by the Contact Center staff.

## Referrals

Referrals are required for TRICARE Prime and TRICARE Prime Remote (TPR) beneficiaries when a PCM is unable to provide a specialized medical service. Most referrals are valid for 180 calendar days from the date of issuance and are subject to TRICARE eligibility requirements. Issuance of a referral does not guarantee payment by TRICARE. See the *TRICARE Behavioral Health Care Services* quick reference chart for an overview of behavioral health care requirements.

### Urgent Referral Request Process

For specialty care within 72 hours or less, or for an urgent issue, the appointment process must be expedited. Refer to Section 7 of the *TRICARE Provider Handbook* for more information.

1. PCM coordinates scheduling an appointment with the specialist for the patient.
2. PCM submits a referral request online or by fax so a TriWest reference number can be issued.
3. PCM faxes a copy of the approved referral and beneficiary information to the specialist's office. The specialist may also obtain immediately the information if registered at [www.triwest.com/provider](http://www.triwest.com/provider).

## Submitting Specialty Care Reports

The TRICARE West Region contract requires providers to submit their specialist reports (*consultation, operative, therapy, imaging, and final reports; discharge summaries; reports regarding any additional procedures or skilled therapies; etc.*) to the referring provider within 10 working days of the specialty encounter.

In urgent or emergency situations, a preliminary report of a consultation must be conveyed to the TRICARE beneficiary's PCM within 24 hours by telephone, fax, or other means. A formal, written consult report is due to the referring provider within 10 working days after the visit or procedure. **Note:** The 10-day requirement is not applicable to Alaska providers.

### Referral Resources

Download <i>TRICARE Patient Referral/Authorization Form</i>	<a href="http://www.triwest.com/provider">www.triwest.com/provider</a> , "Find a Form" tab
Fax TRICARE Prime requests	1-866-269-5892
Fax TPR and TRICARE Reserve Select requests	1-866-312-5831



# TRICARE Referrals and Prior Authorizations

## Prior Authorizations

Prior authorization is the process of reviewing certain medical, surgical, and behavioral health care services to ensure medical or psychological necessity and appropriateness of care. It must be submitted to TriWest prior to services being rendered. Prior authorization for medical or surgical services will have a begin date and an end date. Behavioral health care authorizations are valid for the number of visits specified and will also have a begin date and an end date. Prior authorization is required for requested services, procedures, or admissions that require medical necessity review prior to services being rendered. Prior authorization is not a guarantee of payment. See Section 7 of your *TRICARE Provider Handbook* for additional prior authorization requirements.

## Prior Authorization Requirements by Program Type

Obtain prior authorizations in the following instances for beneficiaries using TRICARE Prime and TRICARE Prime Remote, TRICARE Standard, TRICARE Extra, and TRICARE Reserve Select, or TRICARE coverage combined with other health insurance.

TRICARE Prime and TRICARE Prime Remote	TRICARE Standard, TRICARE Extra, and TRICARE Reserve Select	Other Health Insurance
<ul style="list-style-type: none"> <li>• Before procedures are performed by a specialist</li> <li>• Before performing procedures on the Prior Authorization List, located at <a href="http://www.triwest.com/provider">www.triwest.com/provider</a></li> <li>• Before nonemergency or behavioral health admission to a facility</li> </ul>	<ul style="list-style-type: none"> <li>• Before performing procedures on the Prior Authorization List, located at <a href="http://www.triwest.com/provider">www.triwest.com/provider</a></li> <li>• Before nonemergency or behavioral health admission to a facility</li> </ul>	Prior to administering the following: <ul style="list-style-type: none"> <li>• Behavioral health services (<i>with the exception of the initial eight self-referred outpatient visits</i>)<sup>1</sup></li> <li>• Adjunctive dental care</li> <li>• Extended Care Health Option (ECHO) services</li> <li>• Solid organ and stem cell transplants</li> </ul>

1. Medicare-eligible beneficiaries do not need prior authorization for behavioral health care admissions when Medicare is the primary payer.

## Expediting a Prior Authorization Request

- Submit requests online at [www.triwest.com/provider](http://www.triwest.com/provider).
- Be specific about the requested services and provide the most appropriate procedure/diagnosis codes.
- Submit **completed** request forms with physician documentation and all clinical indications, including laboratory/radiology results, related to the service.
- Verify and include the beneficiary's demographic information on the authorization request form.
- Identify photographs needed to support service requests with the beneficiary's date of birth and the sponsor's SSN. Attach photos to the online request or mail (*do not fax*) to the local TriWest hub office. Refer to [www.triwest.com/provider](http://www.triwest.com/provider) for a list of hubs, states covered by each hub, and mailing addresses.
- Request a new authorization if additional services are required.

## Authorization of Additional Care

- If the beneficiary needs additional or continued care:
  - Specialist must communicate with the referring provider (*civilian or military treatment facility [MTF]*) and TriWest for continuity of care.
  - Specialist may request authorization for additional services with the same diagnosis as the original referral or authorization. If additional services are required for a different diagnosis, the beneficiary should be directed back to his or her PCM.
  - If possible, the beneficiary will receive care at the MTF. If services are not available at the MTF, network providers must be used, if available.

## Penalties for Non-Compliance with Prior Authorization Procedures

Network Providers and Non-Network Providers	Providers can request a post-service, prepayment review of TRICARE claims without required authorization if the claim has been denied. If the claims can be paid after review, providers will be assessed a penalty, which cannot be billed to the beneficiary. If the beneficiary did not advise the provider of TRICARE coverage before the services were rendered, the provider will not be penalized.
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