TRIWEST HEALTHCARE ALLIANCE®

Previous Authorization Number:

SECONDARY AUTHORIZATION REQUEST (SAR) FORM Fax to **1-866-259-0311**

SECTION I: PATIENT INFORMATION

Last Name:	First Name:	DOB:	SSN:
Address:	City:	State:	Zip:

SECTION II: REQUESTING PROVIDER INFORMATION

Requesting Provider:	Contact Person:
TIN:	Phone:
Address:	Fax:
Specialty (type):	Group Name:

SECTION III: TYPE OF CARE REQUEST

Please indicate CLINICAL urgency: →→→ ☐ Routine ☐ Urgent ☐ Emergent	**Urgent care is only applicable if a processing time of greater than 2 business days could seriously jeopardize the life or health of the Veteran or their ability to regain maximum function, OR would subject the Veteran to severe pain that cannot be adequately managed without the care/treatment being requested. Do NOT mark urgent for administrative urgency. Medically necessary emergent care should be rendered and documentation submitted later.**

Diagnosis: (ICD-10 Code/Description):

Date of Service and/or Anticipated Length of Care:

CPT/HCPCS Code and/or Description
of Requested Service (include units/visits,
add second list page, if needed):

How many visits have occurred so far? (If known)

Is this a referral to another specialty? ☐ Yes ☐ No If yes, please fill out the Servicing Provider/Specialty information below.

Servicing Provider/Specialty:	Contact Person:
TIN:	Phone:
Address:	Fax:
Facility:	Contact Person:
TIN:	Phone:
Address:	Fax:

SECTION IV: TYPE OF SERVICES REQUESTED

☐ PT ☐ OT ☐ Speech Therapy Frequency and duration:	Surgical Procedure: ☐ Inpatient ☐ Outpatient (List facility name in Section III & Complete Discharge Needs (Section VI))
☐ In-Office Procedure	Inpatient Care: ☐ SNF ☐ Acute Rehab ☐ BH

☐ Additional Office Visits (list # needed):	☐ Extension of Validity Dates	☐ Emergency Room Care
☐ Labs: (If done outside of office, please provide a facility above)	☐ Radiology / Imaging (Utilize the facility box if outside of office)	

☐ Pre-Op Labs ☐ Chest XRAY ☐ EKG Other: ☐ Type & Screen ☐ Type & Cross

SECTION V: CLINICAL INFORMATION

To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results and or medications to support the medical necessity of services requested. Additional information attached?: ☐ Yes ☐ No

Admission or Discharge Information:	

SECTION VI: DISCHARGE NEEDS

(Must be completed if requesting Inpatient Admission / Procedure)

☐ **DME –** Item Description & HCPCS Codes
(to be provided by VAMC):

☐ **Home Health or Home Infusion Care –**
List specific services, duration and/or frequency:

☐ **Skilled Nursing Facility**	☐ **Inpatient Acute Rehab**

☐ **Other** Needs:

To facilitate timely review of this request, the most recent office notes and plan of care must accompany this form. TriWest will review for completeness and submit to VA if required. To submit a request, please fax to 1-866-259-0311.

If VA review is required, the turnaround time can be up to fourteen (14) calendar days. You can check the status of the request on the provider portal at: www.triwest.com/provider

Revised May 2018