



TRICARE PATIENT REFERRAL/AUTHORIZATION FORM



Patient Name \_\_\_\_\_ Patient SSN \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Home Telephone \_\_\_\_\_

Sponsor Name \_\_\_\_\_ Sponsor SSN \_\_\_\_\_

Patient's Relationship to Sponsor \_\_\_\_\_

Requesting Provider \_\_\_\_\_ TIN \_\_\_\_\_

Contact Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

Requested Service \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Service \_\_\_\_\_ # of Visits \_\_\_\_\_

CPT4/HCPCS Code(s) (List all) \_\_\_\_\_

Inpatient  Outpatient Facility  Home  Office (Select One)

Emergency  Routine  Urgent (Select One)

Servicing Provider/Specialty \_\_\_\_\_ TIN \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Facility \_\_\_\_\_ TIN \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Please 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, please 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. The medical records requested are necessary for the conduct of health care operations.

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