Patient referral authorization form

Patient name: ____

DOB (mm-dd-yyyy)**:** ______________________________ **TRICARE ID:** ______________

Sponsor address: ____

Other Health Insurance: ☐ Yes ☐ No **Carrier:** ______________________________

Policy # ______________________________ **Phone:** ______________

Provider or setting: ☐ Physician's office ☐ Allied health professional's office ☐ Outpatient facility ☐ Inpatient facility

Date of service (if known; mm-dd-yyyy)**:** ____________________ ☐ Evaluate only ☐ Evaluate and treat

Point of contact: ____

Ordering provider: ______________________________ **Phone:** ______________

Type of service: ☐ Office visit **List specialty:** ______________ **Specialist Tax ID/NPI:** ______________

☐ Surgical/Diagnostic procedure ☐ Speech therapy ☐ Hospice ☐ Home health ☐ DME ☐ Observation ☐ PT/OT

☐ OP behavioral health ☐ Other ☐ Inpatient admission: ☐ Acute care ☐ Rehab ☐ SNF

If inpatient, please provide a diagnosis code: ______________________________

Procedure or HCPC code: ____

Facility: ______________________________ **Tax ID/NPI:** ______________

Address: ____

Rendering provider: ______________________________ **Tax ID/NPI:** ______________

Address: ____

Presenting symptoms or reason for referral: ______________________________

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Pertinent history, findings and specials situations include known discharge needs if inpatient admission: ______________

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TRICARE referrals should be submitted through HumanaMilitary.com/ProvSelfService. If you do not have internet connection in your office, you may complete and submit this form by fax to 1-877-548-1547. The military hospital or clinic in your area may have Right of First Refusal for this service.

(01/2018)