TRICARE West Region Patient Referral/Authorization Form

For Provider Use Only

Patient Information

Patient Last Name: _____

Patient First Name: _____

Patient DOD ID: _____

Patient Date of Birth (MM/DD/YYYY): _____

Patient Address

Street: _____

City: _____ State: _____ ZIP: _____

Patient Telephone: _____

Sponsor Last Name: _____ Sponsor First Name: _____

Sponsor DOD ID: _____ Patient's Relationship to Sponsor: _____

Requesting Provider Information

Provider: _____ Contact Name: _____

Provider Address

Street: _____

City: _____ State: _____ ZIP: _____

Provider TIN: _____ Provider NPI: _____

Provider Telephone: _____ Provider Fax: _____

Diagnosis: _____ ICD-10: _____

Requested Service: _____ Date of Service (MM/DD/YYYY): _____

CPT/HCPC Code(s): _____ ○ Inpatient ○ Outpatient

○ Emergency ○ Routine ○ Urgent ○ Home/Telehealth

Servicing Provider Information

Servicing Provider Name: _____

Servicing Provider Address

Street: _____

City: _____ State: _____ ZIP: _____

Servicing Provider TIN: _____ Servicing Provider NPI: _____

Servicing Provider Telephone: _____ Servicing Provider Fax: _____

Facility Information

Facility Name: _____

Facility Address

Street: _____

City: _____ State: _____ ZIP: _____

Facility TIN: _____ Facility NPI: _____

Facility Telephone: _____ Facility Fax: _____

Please attach clinical notes, appropriate lab results, diagnostic test 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 including medical records requested for the provision of health care services.

Return the completed form via fax to 866-852-1893.