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: MIchelle Smith,PMHNP

Servicing Provider Address

Street: 1790 North State Street

City: Orem | State: UT | ZIP: 84057

Servicing Provider TIN: 20-3687800 | Servicing Provider NPI: 1184689850

Servicing Provider Telephone: 801.224.8255 | Servicing Provider Fax: 801.224.8301

Facility Information

Facility Name: Center For Change

Facility Address

Street: 1790 North State Street

City: Orem | State: UT | ZIP: 84057

Facility TIN: 20-3687800 | Facility NPI: 1184689850

Facility Telephone: 801.224.8255 | Facility Fax: 801.367.8998

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.