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: _____

_____

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)