

TRICARE PRIME PUERTO RICO
PATIENT REFERRAL AUTHORIZATION FORM

Complete and submit this form by fax to 1-800-788-1366.

*The Military Treatment Facility (MTF) in your area may have Right of First Refusal for this service.
You may wish to wait for authorization prior to scheduling the patient appointment.
Referral is based on medical necessity, subject to TRICARE eligibility, and is not a guarantee of payment.*

SECTION I: PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Sponsor's SSN: _____ Sponsor's Name: _____ Phone: _____

SECTION II: OTHER HEALTH INSURANCE

Policy Holder: _____ Policy ID #: _____
Carrier Name: _____ Effective Date: _____
Carrier Phone Number: _____ Service Approved by OHI: Yes No Not Needed

SECTION III: PCM INFORMATION

PCM Contact Person: _____ Phone: _____ Fax: _____
PCM Name: _____
PCM Signature: _____

Referred to Specialty (type): _____ Contact Person: _____
Phone: _____ Fax: _____
Specialist Name (optional): _____

Facility Name: _____ Facility Tax ID: _____
Admitting Physician: _____ Contact Person: _____
Phone: _____ Fax: _____

SECTION IV: REFERRAL INFORMATION

- Evaluation Only Evaluation and Treat
- Home Health Home Infusion Hospice Inpatient Admission: Acute Care Rehab SNF
- Surgical/Diagnostic Procedure (list):
 - Inpatient Outpatient
- DME (describe equipment)
- Observation Speech Therapy PT/OT Other

SECTION V: CODES

ICD 9 Diagnosis Code/Description of Diagnosis (and/or CPT codes):

SECTION VI: CLINICAL INFORMATION

(To avoid delays include appropriate documentation such as office notes, current treatment plan, clinical history, laboratory results, radiology results and/or medications to support the medical necessity of services requested.) Additional information submitted: Yes No
Service Date (if known): _____

SECTION VII: ANTICIPATED DISCHARGE NEEDS

- DME Home Health Rehab SNF Therapies IV Infusion