



PATIENT REFERRAL AUTHORIZATION FORM

TRICARE referrals should be submitted through
www.humana-military.com (select 'Online Provider Services').
 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 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Needed

SECTION III: PROVIDER INFORMATION

PCM Contact Person:	Referred to Specialty: (type)	Facility Name:
Phone:	Contact Person:	Facility Tax ID:
Fax:	Phone : Fax :	Admitting Physician:
PCM Name:	Specialist Name: (optional)	Contact Person:
PCM Signature:	Phone : Fax :	

SECTION IV: REFERRAL/AUTHORIZATION INFORMATION

<input type="checkbox"/> Evaluation Only	<input type="checkbox"/> Home Health <input type="checkbox"/> Home Infusion <input type="checkbox"/> Hospice
<input type="checkbox"/> Evaluation and Treat	<input type="checkbox"/> Inpatient Admission: <input type="checkbox"/> Acute Care <input type="checkbox"/> Rehab <input type="checkbox"/> SNF
<input type="checkbox"/> Surgical/Diagnostic Procedure: (list) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> DME (describe equipment)
<input type="checkbox"/> Observation	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> PT/OT	<input type="checkbox"/> 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