HUMANA MILITARY HEALTHCARE SERVICES

TRICARE South Region Case Management Referral Form
Medical Surgical – HMHS

Beneficiary Name	Date of Birth	
Sponsor Social Security Number	Beneficiary/Responsible Person Phone Number	
Provider ` []PCM []Attending	Office Mailing Address	City/State & Zip
Phone Number (Office or Clinic)	Fax Number (Office or Clinic)	Pager Number for Provider ________________________________ Provider Email Address

DIAGNOSIS / Clinical History/Reason(s) for Referral (include social problems): (fax and or mail any pertinent clinical information available)		
Point of Contact for More Information	Name	Number
Inpatient? [] Yes [] No	If Inpatient – Facility Name	
Date of Referral	Name of Person Making Referral and Title	Phone/Fax Number for Person Making Referral Phone: Fax:

MTF Fax Number for Case Management Acceptance Decision:

Contractor's Use Only Date Referral Received Decision [] Accept [] Not Accept

Rationale for Decision

Case Manager :

Decision Date: Phone: Fax:

Medical/Surgical Referral Guidelines

Tier II

[] 1. ECHO
[] 2. Transfers (excludes MTF to MTF)
[] 3. High dollar customized Durable Medical Equipment (e.g. wheelchair)

Tier III (catastrophic, complex, chronic high utilization care needs)

[] 1. Unstable beneficiary with multiple providers and high dollar utilization requirements
[] 2. Transplantation Evaluation or actual procedure (Solid organ or bone marrow/peripheral stem cell)
[] 3. Ventilator dependent beneficiary
[] 4. Traumatic Brain Injury, Spinal Cord Injuries, CVA, burn or any diagnosis requiring a rehabilitation admission
[] 5. New quadriplegic or paraplegic
[] 6. Premature infant, ventilator dependent> 24 hours and or weight less than 1500 grams
[] 7. Planned Long Term Acute Care (LTAC) admission
[] 8. Catastrophic illness or injury, NOI
[] 9. OB patient with significant identified risks
[] 10. Requests for hourly Nursing > 4 hrs. per day
[] 11. Receiving high cost treatment including medications (e.g. hemophilia, Gaucher's Disease)
[] 12. Other____

To make a **Medical/Surgical** referral, please fax this form to the appropriate market for your MTF.

San Antonio Market	Biloxi Market	Augusta Market
210 614 4692	228 385 5138	706 854 8604