VALUEOPTIONS

TRICARE SUBSTANCE ABUSE REHABILIATION GROUP THERAPY REQUEST

P.O. Box 551188, Jacksonville, Fl 32255-1188 Fax: **1-866-811-4422**

IDENTIFYING DATA FILL OUT COMPLETELY TO AVOID DELAYS

Patient's Name:_____ DOB:_____ Sponsor #:_____

FACILITY INFORMATION

Facility Name: _____ Phone#: Phone #:(_____)_____ Fax#:(_____)_____

DSM-IV TR Diagnosis

Axis I - _ _ _._ _ / _ _ _._ _ / _ _ _._ _ Axis II - _ _ _._ _ / _ _ _._ _ Axis III - _____

Current Clinical Information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Program Information:

Start date:_____ Estimated End Date:_____

Program Meets: M T W TH F S SU (CIRCLE ALL THAT APPLY)

GROUPS PER DAY:_____

LENGTH OF EACH GROUP ***IN MINUTES:***_____

_____ _____

Requesting Provider's Signature Date

Note: TRICARE Policy Manual 6010.54-M; Chapter 7, Section 3.7.
In order to be eligible for cost sharing, outpatient substance abuse treatment must be rendered by a TRICARE approved facility-based program.

Disclaimer: Authorization indicates that ValueOptions-TRICARE has determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered.