ValueOptions
TRICARE OUTPATIENT RETROSPECTIVE Review Form (Penalty Applies)

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

PLEASE PRINT **FILL OUT *COMPLETELY* TO AVOID DELAYS**

IDENTIFYING DATA

Patient's Name:__________________________ DOB:_______________ Sponsor #:________________________

DSM-IV TR Diagnosis

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

TREATMENT REPORT
Clinical Information for each date(s) of service is required to support medical necessity to validate services rendered. (Attach additional clinical notes if necessary.)

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REQUESTED AUTHORIZATION: (limit 8 dates of service per form.)

CPT Code:____________ DATE(S) OF SERVICE:____

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CPT Code:____________ DATE(S) OF SERVICE:____

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Provider Name:____________________________ Phone #: (____)___________ Fax #: (_____)____________

____ ______________________ ________________
Provider's Signature Licensure Date

Disclaimer: Authorization indicates that ValueOptions 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.

04/08