

ValueOptions
TRICARE Dental Anesthesia & Facility Prior Authorization Request
P.O. Box 551188,, Jacksonville, Florida 32255-1188
Telephone: (800)-700-8646 Fax: (866)-811-4422

(This form is only to be used for beneficiaries with a primary diagnosis of 290.0-319. Diagnoses out of this range should be forwarded to Humana Military Healthcare Services for processing.)

SECTION I: PATIENT INFORMATION

Last Name:	First Name:	Age:	DOB:
Address:	City:	State:	Zip:
Sponsor's SSN:	Sponsor's Name:	Telephone Number:	

SECTION II: PROVIDER / FACILITY INFORMATION

PCM	Referred to Specialty: (type)	Facility Name:
Telephone:	Contact Person:	Facility Tax ID:
Fax:	Telephone: Fax:	Admitting Physician:
Provider NPI:	Specialist Name: (Optional)	Contact Person:
PCM Signature:	Telephone:	Fax:

SECTION III: CODES

AXIS I:	AXIS II:	AXIS III:
ICD-9:	CPT Codes:	

SECTION VI: AUTHORIZATION INFORMATION

<input type="checkbox"/> Outpatient:
<input type="checkbox"/> Inpatient:
<input type="checkbox"/> Procedure (List):

SECTION V: CLINICAL INFORMATION

Service Date (if known): _____

 Provider's Signature

 Date

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 service(s) are rendered.