Patient Referral Authorization Form

TRICARE referrals should be submitted through <u>www.humanamilitary.com</u> (log on to Self-Service for Providers). If you do not have internet connection in your office, you may complete and submit this form by fax to 1-877-548-1547.

Humana, Government Business



The Military Treatment Facility (MTF) in your area may have Right of First Refusal for this service.

| 9-11 Digits | Patient Name |
|---|--|
| Patient DOB | Patient Zip Code |
| Address | City State |
| Other Health OYes Carrier Insurance? ONo | Phone |
| Provider or Setting | |
| Physician's Office | ed Health Professional's Office Outpatient Facility Inpatient Facility |
| Date of Service | - Point of Contact |
| Evaluate Only Ordering | |
| Evaluate and Treat Provider | |
| Type of Service | |
| Office Visit List Specialty | Specialist Tax ID or NPI |
| Surgical/Diagnostic Procedure | Speech Therapy Hospice DME Other |
| Observation | Home Health PT/OT OP Behavioral Health |
| I Innatient Admission | cute Rehab SNF If inpatient, please Discrete Rehab SNF Provide a diagnosis code: |
| Procedure or HCPC Code | |
| Facility | Tax ID or NPI Address |
| City | State Zip Code |
| Rendering Provider | Tax ID or NPI Address |
| City | State Zip Code |
| Presenting symptoms or reason for referral. | |
| | |

Pertinent history, findings and specials situations include known discharge needs if inpatient admission.