

Patient referral authorization form

Patient name: _____

Phone: _____ TRICARE ID: _____ DOB (mm-dd-yyyy): _____

Sponsor address: _____

Other Health Insurance: Yes No Carrier: _____

Policy #: _____

Provider or setting: Physician's office Allied health professional's office Outpatient facility Inpatient facility

Date of service (if known; mm-dd-yyyy): _____ Evaluate only Evaluate and treat

Point of contact: _____ Phone: _____ Fax: _____

Ordering provider: _____ Phone: _____ Fax: _____

Type of service: Office visit List specialty: _____ Specialist Tax ID/NPI: _____

Surgical/Diagnostic procedure Speech therapy Hospice Home health DME Observation PT/OT

OP behavioral health Other Inpatient admission: Acute care Rehab SNF

If inpatient, please provide a diagnosis code: _____

Procedure or HCPC code: _____

Facility: _____ Tax ID/NPI #: _____

Address: _____

Rendering provider: _____ Tax ID/NPI #: _____

Address: _____

Presenting symptoms or reason for referral: _____

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



TRICARE referrals should be submitted through [HumanaMilitary.com/ProvSelfService](https://www.humanamilitary.com/ProvSelfService). If you do not have internet connection in your office, you may complete and submit this form by fax to (877) 548-1547. The military hospital or clinic in your area may have Right of First Refusal for this service.