

TRICARE REFERRAL AUTHORIZATION REQUEST FORM

This form is to be completed by your primary care physician.

The primary care physician will need to complete the following sections:

5. Requesting Provider Information
6. Patient Information
7. Requested Service Information—most requests are for evaluation and Treatment
8. Clinical History—this provides the medical necessity information

Once complete, the physician should fax the request to the number listed in the upper right corner of the form.



HEALTH NET FEDERAL SERVICES
TRICARE SERVICE REQUEST/NOTIFICATION FORM

Fax to: 1-888-299-4181

Requesting Provider Information

Requesting Provider Telephone Number: () - Attachments - Number of Pages:
Requesting Provider Fax Number: () - Service Type: Specialty Referral [X]
Contact Name: Outpatient []
Requesting Provider/Facility Name: Inpatient []
Physician State License #: DME []
Billing Tax ID #: Home Health []
Requesting Provider NPI: IV Therapy []
Is the Requesting Provider Performing the Service? Yes [] No [] PHP []
Correspondence Preference: [] Fax (fill-in Fax # above) Email [] Address [] US Mail []

Patient Information (Please complete all fields)

Sponsor SSN: - - Patient Date of Birth (mm/dd/yyyy): / /
Patient Name (Last, First, MI):
Patient Address: Street City State Zip Code
Patient Home Phone: () -
Other Health Insurance? No [] Yes [] If Yes, Insurance Name & Policy #:

Servicing Physician/Provider Information (Complete this section if the Requesting Provider is Not Performing the Service)

Servicing Physician/Provider Name: MARGARET GAGLIONE Phone: 757 644-6819
Specialty: BARIATRICS Fax: 757 644-6816
Servicing Provider NPI: 1422339076 Phone: () -
Facility Name (If Applicable): TIDEWATER BARIATRICS Fax: () -
Address: 1405 KENFVILLE RD, CHESAPEAKE, VA Zip Code: 23320
Street City State

Requested Service Information (Complete as many sections as required)

Anticipated Date of Service (mm/dd/yyyy): / / Request Priority: Routine [] Urgent []
Diagnosis: ICD-9 Code: - Description:
Service 1: CPT/HCPC/NDC Code: Description:
Number of Visits: Frequency: Daily [] Weekly [] Monthly [] Duration: Days [] Weeks [] Months []

Additional Services (if necessary)

Service 2: CPT/HCPC/NDC Code: Description:
Number of Visits: Frequency: Daily [] Weekly [] Monthly [] Duration: Days [] Weeks [] Months []
If DME: Purchase [] Rental []
Service 3: CPT/HCPC/NDC Code: Description:
Number of Visits: Frequency: Daily [] Weekly [] Monthly [] Duration: Days [] Weeks [] Months []
If DME: Purchase [] Rental []

Clinical History/Previous Treatment/Plan of Treatment, supporting lab/x-ray reports, etc.

Complete These Sections for Specialty Referrals

Complete These Additional Sections for all Other Request Types

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