

# Patient Referral Authorization Form

TRICARE referrals should be submitted through [www.humana-military.com](http://www.humana-military.com) (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 Military



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

TRICARE ID 9-11 Digits

Patient Name

Patient DOB MM-DD-YYYY

Patient Zip Code

Address

City

State

Other Health Insurance?  Yes  No

Carrier

Phone

Policy#

## Provider or Setting

Physician's Office  Allied Health Professional's Office  Outpatient Facility  Inpatient Facility

Date of Service (If known) MM-DD-YYYY

Point of Contact

Evaluate Only

Ordering Provider

Phone

Evaluate and Treat

## Type of Service

Office Visit

List Specialty

Surgical/Diagnostic Procedure

Speech Therapy

Hospice

DME

Other

Observation

Home Health

PT/OT

OP Behavioral Health

Inpatient Admission:

Acute Care

Rehab

SNF

If inpatient, please provide a diagnosis code:

Procedure or HCPC Code

Facility

Address

City

State

Zip Code

Rendering Provider

Address

City

State

Zip Code

Presenting symptoms or reason for referral.

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