Patient referral authorization form

Patient name:	
DOB (mm-dd-yyyy):	TRICARE ID:
Sponsor address:	
Other Health Insurance: Yes No Carrier:	
Policy #	
Provider or setting: ☐ Physician's office ☐ Allied health professional's of ☐ ☐ Allied health professional's Office ☐ Office ☐ Allied health professional's Office ☐ Allied health professional's Office ☐ Allied health professional Declaration ☐ Allied health profession ☐ Allied health Declaration ☐ Alli	office Outpatient facility Inpatient facility
Date of service (if known; mm-dd-yyyy):	□ Evaluate only □ Evaluate and treat
Point of contact:	
Ordering provider:	Phone:
Type of service: ☐ Office visit List specialty:	Specialist Tax ID/NPI:
☐ Surgical/Diagnostic procedure ☐ Speech therapy ☐ Hospice ☐	
☐ OP behavioral health ☐ Other ☐ Inpatient adn	nission: Acute care Rehab SNF
If inpatient, please provide a diagnosis code:	
Procedure or HCPC code:	
Facility:	
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. If you do not have internet connection in your office, you may complete and submit this form by fax to 1-877-548-1547. The military hospital or clinic in your area may have Right of First Refusal for this service.