Submitting Referral and Authorization Requests

Referral and Prior Authorization Guidelines

1. Fill out TRICARE Patient Referral/Authorization Form with the following information:
   - Sponsor’s name and Social Security number
   - Beneficiary’s name, date of birth, address, and telephone number
   - Type of service requested
   - Diagnosis and diagnosis code
   - Procedure(s) or durable medical equipment (DME) requested and procedure or HCPCS code(s)
   - Date of service
   - Facility name, tax identification (ID) number, address, telephone/fax numbers
   - Referring/requesting provider’s tax ID number, full name, entire address, telephone/fax numbers with area codes
   - Specialist’s tax ID number, full name, entire address, telephone/fax numbers with area codes

2. Fax completed form to the fax number listed on the bottom of the form.
   To avoid processing delays, send only one completed TRICARE Patient Referral/Authorization Form per fax and fax request only once.

Referrals

Referrals are required for TRICARE Prime/TPR beneficiaries when a primary care manager (PCM)/primary care provider is unable to provide a specialized medical service. Most referrals are valid for 90 calendar days from the date of issuance and are subject to TRICARE eligibility. Issuance of a referral does not guarantee payment by TRICARE.

Urgent Referral Request Process

For specialty care within 72 hours or less, or for an urgent issue, the appointment process must be expedited.

1. PCM coordinates scheduling an appointment with the specialist for the patient.
2. PCM completes the referral request process so a tracking number can be issued.
3. PCM faxes a copy of the approved referral and beneficiary information to the specialist’s office.

Submitting Specialty Care Reports

TriWest will notify the specialist or facility via letter with the information needed to submit all clinically warranted reports to the PCM within 10 working days of the initial appointment date (e.g., consultation, follow-up, operative, or therapy reports, imaging studies, discharge summaries, etc.).

In urgent/emergency situations, a preliminary report of a consultation must be conveyed to the TRICARE beneficiary’s PCM within 24 hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax, or other means. A formal written consult report is due to the referring provider within 10 working days* after the visit/procedure.

* 10-day requirement is not applicable to Alaska providers.

Referral Resources

| Download TRICARE Patient Referral/Authorization Form | www.triwest.com, “Find a Form” tab |
| Fax TRICARE Prime requests | 1-866-269-5892 |
| Fax TRICARE Prime Remote requests | 1-866-312-5831 |

The information in this chart may contain updates that were not printed in the TRICARE Provider Handbook.
Prior Authorizations

Prior authorization is required for requested services, procedures, or admissions that require medical necessity review prior to services being rendered. Prior authorization is not a guarantee of payment.

Prior Authorization Requirements by Program Type

Obtain prior authorizations in the following instances for beneficiaries using TRICARE Prime, TRICARE Standard and TRICARE Extra, or TRICARE coverage combined with other health insurance.

### TRICARE Prime
- Before procedures performed by a specialist
- Before beneficiary admission to a facility

### TRICARE Standard/ TRICARE Extra
- Before performing procedures on the Medical Necessity Review List at [www.triwest.com](http://www.triwest.com)

### Other Health Insurance
- Prior to administering the following:
  - Behavioral health services
  - All nonemergent inpatient admissions for substance use disorder or behavioral health
  - Partial hospitalization programs and residential treatment center programs
  - Psychoanalysis
  - Psychotherapy after the initial eight outpatient visits
  - Adjunctive dental care
  - Extended Care Health
  - Option (ECHO) services
  - Home health services
  - Hospice services
  - Solid organ and stem cell transplants

1. Medicare-eligible beneficiaries do not need prior authorization for behavioral health admissions when Medicare is the primary payer.

Expediting a Prior Authorization Request

- Be specific about the requested services and provide the most appropriate procedure/diagnosis codes.
- Submit completed request forms with physician documentation and all clinical indications, including laboratory/radiology results, related to the service.
- Verify the beneficiary’s demographic information and include on the authorization request form.
- Mail (do not fax) photographs needed to support the requested service and identify with beneficiary’s date of birth and sponsor’s SSN (provide address to return photos).
- Submit a request for a new authorization for additional services required.

Authorization of Additional Care

If the beneficiary needs additional or continued care:

- Specialist must communicate with referring provider (civilian or MTF) and TriWest for continuity of care.
- If possible, the beneficiary will receive care at the MTF. If services are not available there, the MTF must request a new authorization from TriWest. Network providers must be used if available.

Penalties for Non-compliance with Prior Authorization Procedures

| Network Providers | Providers can request a post-service, prepayment review of TRICARE claims without required authorization, when authorization is subsequently obtained. If the claims can be paid after review, providers will be assessed a penalty which cannot be billed to the beneficiary. If the beneficiary did not advise the provider of TRICARE coverage before the services were rendered, the provider will not be penalized. |
| Non-network Providers | TRICARE claims submitted without required authorization will be denied. |

Services Requiring Prior Authorization

Refer to [www.triwest.com](http://www.triwest.com) for the most current Medical Necessity Review list to determine which services require prior authorization.

### Mail photographs to support authorization request:

Mail photographs to the local TriWest hub office. Refer to [www.triwest.com](http://www.triwest.com) for a list of hubs, states covered by each hub, and mailing addresses.

### Request post-service prepayment review:

Wisconsin Physicians Service (WPS)
P.O. Box 77028
Madison, WI 53707-1028