Patient Referral Authorization Form

TRICARE referrals should be submitted through www.humana-military.com (log on to MyHMHS 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.

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

Sponsor SSN

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
☐ Evaluate and Treat

Ordering Provider

Phone

Type of Service

☐ Office Visit List Specialty:

☐ Surgical/Diagnostic Procedure ☐ Speech Therapy ☐ Hospice ☐ DME
☐ Observation ☐ Home Health ☐ PT/OT ☐ Other

☐ Inpatient Admission: ☐ Acute Care ☐ Rehab ☐ SNF If inpatient, please provide a diagnosis code:

Procedure or HCPC Code

Rendering Provider

Address

City

State

Zip Code

Facility

Address

City

State

Zip Code

Presenting symptoms or reason for referral.

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

To assist with timely processing, please complete this form in its entirety.