HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Outpatient Request Form

Submit requests online at www.tricare-west.com for easy submission and quick status updates or fax to 1-844-429-8653.

Clinical Priority: Care must be rendered:

- ☐ Routine–must be seen within 28 days
- ☐ Urgent–must be seen within 72 hours*

***Clinical justification for Urgent priority must be attached or noted below. If not provided, request will be processed as Routine.**

Service Type

	☐	Specialty Referral/Global Maternity
Q1	☐	Physical or Occupational Therapy
	☐	OP Behavioral Health
Q2	☐	OP Medical Care/Procedure
	☐	DME/Radiology
	☐	Speech Therapy
Q3	☐	Outpatient Surgery
	☐	IV Therapy/Home Health
	☐	Adjunctive Dental
	☐	Hospice/Respite Care
IP		*Note:* Inpatient services must be requested using the Inpatient TRICARE Service Request/Notification Form.

Requesting Provider Information

Requesting Provider Telephone Number: ( ) -

Requesting Provider Fax Number: ( ) -

Contact Name:

Requesting Provider/Facility Name:

Physician State License #:

Requesting Provider NPI #:

Billing Tax ID #:

Essential Service Information

Is this a continuation/extension of services? ☐ Yes ☐ No

Date of Service: ☐☐ / ☐☐ / ☐☐☐☐

Patient Information (Please complete all fields.)

Sponsor SSN/DOD Benefits Number:

Patient Name (Last, First, MI): Patient Date of Birth: / /

Patient Address: ZIP Code:

Street City State

Patient Home Phone: ( ) - Other Health Insurance:

Servicing Provider Information (Complete all applicable fields.)

Specialty:

Servicing Provider Name: Provider NPI: Phone: ( ) -

Address: Fax: ( ) -

Facility Name (If Applicable): Facility NPI: Phone: ( ) -

Address: Fax: ( ) -

Requested Service Information

Diagnosis: Code: Description:

Code: Description:

Service 1: CPT/HCPC/NDC Code: Description:

Number of Visits: If DME: ☐ Purchase ☐ Rental

Service 2: CPT/HCPC/NDC Code: Description:

Number of Visits: If DME: ☐ Purchase ☐ Rental

Service 3: CPT/HCPC/NDC Code: Description:

Number of Visits: If DME: ☐ Purchase ☐ Rental

Clinical Justification:

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