



TRICARE Alternative Referral/Authorization Form

Quick Reference Guide

For TRICARE West Region Providers

Key Points

- The online Alternative Referral/Authorization Form replaces faxing. Use the form to submit referral and authorization requests if the online referral management tool is unavailable.
- You must use the Referral/Authorization Decision Support (RADS) tool to determine if a service or TRICARE plan type requires a referral or authorization prior to using the Alternative Referral/Authorization Form.

Introduction

You should submit referrals and authorizations through the online referral management tool in Availity. If the tool is unavailable, or you are unable to select a provider or beneficiary within the tool, use the Alternative Referral/Authorization Form, also available in Availity.

This form replaces the previous submission method of faxing referrals and authorizations. Only use this form as an alternative when you cannot submit a request using the online referral management tool which is still the preferred method.

Before submitting an Alternative Referral/Authorization Form, you must first determine if a referral or authorization is required. This guide will help you submit a referral or authorization request using the Alternative Referral/Authorization Form. It will also cover how to use the Referral and Authorization Decision Support (RADS) tool to determine if a service requires a referral or authorization.

Using the Referral/Authorization Decision Support (RADS) Tool

1. Go to the **Alternative Referral/Authorization Form**. You can find this form on Availity.
 - Go to “Payer Spaces” in the upper menu
 - Choose “TRICARE West”
 - Scroll down to “Applications”
 - Select Alternative Referral/Auth Form



2. Select **Click to Complete RADS tool**. The RADS Tool opens.

Note: Do not close the Alternative Referral/Authorization Form page. The RADS Tool will open in a new window, but you will need the Alternative Referral/Authorization Form page open to complete later steps.

3. Select the beneficiary's TRICARE plan from the **Beneficiary's (Patient) Plan Type** drop-down field.

Note: Some plan types will automatically show the determination results if selected. Additional information and field explanations will appear next to the form.

4. Select the appropriate answer to each multiple-choice question.

Note: The RADS Tool will ask follow-up questions depending on your answers. Ensure you complete each question. If questions are incomplete, the RADS Tool cannot give a determination.



5. Select the service type from the **What is the service type?** drop-down field.
Note: This field provides multiple service categories to choose from. If you are unsure about what category to select, select **None of the Above**. This will let you enter a diagnosis code directly.
6. Review your determination results once you have completed all fields. Select the **Print** button if you want to print a copy of your results.

<p>Beneficiary's (Patient) Plan Type:</p> <p>TRICARE Prime 4</p> <p>Is the beneficiary an active duty service member (ADSM)?</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>Is the servicing provider in-network or non-network?</p> <p><input checked="" type="radio"/> In-Network <input type="radio"/> Non-Network</p> <p>Place of service?</p> <p><input checked="" type="radio"/> InPatient <input type="radio"/> OutPatient</p> <p>What is the service type?</p> <p>Mental Health 5</p>	<p>All non-emergency Mental Health admissions require a prior authorization, continued stay and medical necessity review.</p> <p>Print 6</p>
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Using the Alternative Referral/Authorization Form

1. If the RADS Tool determines a referral/authorization is required and you are unable to access the online referral management tool, go back to the **Alternative Referral/Authorization Form** page/tab.
 - A. Select **Cancel** if the service doesn't require an authorization or referral.
 - B. Select **Yes** if the RADS Tool indicates that the service requires an authorization or referral. The page will update to include additional form fields.

Alternative Referral/Authorization Form

Did the RADS Tool indicate an Authorization or Referral was Required?

Yes No

Authorization or Referral is not required, select Cancel to exit form.

Cancel

B (circled) points to the 'Yes' radio button. **A** (circled) points to the 'Cancel' button.

2. Select the reason you're submitting a request with the Alternative Referral/Authorization Form from the drop-down field.

Did the RADS Tool indicate an Authorization or Referral was Required?

Yes No

What is the reason you are submitting this request through this Alternative option? *

Beneficiary Not Found

Provider Not Found

System Access

System Difficulty

Other

Cancel

2 (circled) points to the drop-down menu.



3. Complete the required **Patient Details** fields. Ensure you complete either the **DOD ID** (preferred) or **DBN** fields, but not both.

Note: You must complete fields marked with a red asterisk (*) to submit the form.

Patient Details 3

DOD ID (10-digit number required if DBN not provided) <input style="width: 95%; height: 25px;" type="text"/>	DBN (11-digit number found on the back of the ID card) <input style="width: 95%; height: 25px;" type="text"/>	
Patient Last Name * <input style="width: 95%; height: 25px;" type="text"/>	Patient First Name * <input style="width: 95%; height: 25px;" type="text"/>	
Patient Date of Birth * <input style="width: 95%; height: 25px;" type="text"/>	Patient Phone Number (must be valid phone number format) * <input style="width: 95%; height: 25px;" type="text"/>	
Street Address * <input style="width: 95%; height: 25px;" type="text"/>		
City * <input style="width: 95%; height: 25px;" type="text"/>	State * <input style="width: 95%; height: 25px;" type="text"/>	ZIP Code * <input style="width: 95%; height: 25px;" type="text"/>

4. Complete the required **Sponsor Details** fields, which are denoted by a red asterisk (*).
 - A. Select **Yes** to autofill the sponsor information if the sponsor and the beneficiary are the same.
 - B. Select a **Priority** and **Type of Service** option once the autofill is complete.

Sponsor Details

A Are the Patient and the Sponsor the Same? Select Yes to automatically fill in the Sponsor details. *
 Yes No 4

Sponsor DOD ID (10-digit number required if DBN not provided) <input style="width: 95%; height: 25px;" type="text"/>	Sponsor DBN (11-digit number found on the back of the ID card) <input style="width: 95%; height: 25px;" type="text"/>
Sponsor Last Name * <input style="width: 95%; height: 25px;" type="text"/>	Sponsor First Name * <input style="width: 95%; height: 25px;" type="text"/>
Patient Relationship to Sponsor * <input style="width: 95%; height: 25px;" type="text"/>	

B

Priority * <input type="radio"/> Routine <input type="radio"/> Urgent/Emergent	Type of Service * <input type="radio"/> Outpatient <input type="radio"/> Inpatient <input type="radio"/> Referral
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5. Complete the required **Requesting Provider Details** fields, which are denoted by a red asterisk (*).

Requesting Provider Details

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Name *	Phone Number (must be valid phone number format) *	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	
Email (Provide a valid email if you wish to receive confirmation of this submission)		
<input style="width: 95%;" type="text"/>		
Street Address		
<input style="width: 95%;" type="text"/>		
City	State	ZIP Code
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Federal Tax ID for the Requesting Provider (9-digit number) *	NPI for the Requesting Provider (10-digit number) *	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	
Phone Number (must be valid phone number format) *	Fax Number (if provided, must be valid phone number format)	
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	

6. Complete the required **Care Details** fields, which are denoted by a red asterisk (*).
Note: You can enter more than one diagnosis code.

Care Details

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Date of Service *	Visit Type *
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Diagnosis Codes *	
<input style="width: 95%;" type="text"/>	
ICD-10 *	
<input style="width: 95%;" type="text"/>	



7. Complete the **Servicing Provider** Details fields.

- A. Select **Yes** to autofill the provider's information if the servicing and requesting providers are the same.

Servicing Provider Details

Are the Servicing and Requesting Provider are the Same? Select Yes to automatically fill in the Servicing details. *

Yes No

A

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Servicing Provider Name *

Email (provide valid email is a confirmation of submission is requested)

Street Address

City State ZIP Code

Federal Tax ID for the Servicing Provider (9-digit number) * NPI for the Servicing Provider (10-digit number) *

Phone Number (must be valid phone number format) * Fax Number (if provided, must be valid phone number format)



- 8. Complete the optional **Facility Details** fields if appropriate.
 - A. Select **Yes** to autofill the provider's information if the facility and servicing providers are the same.
- 9. Select Submit.
Note: The submission won't go through if required fields are blank. Complete all required fields to submit the form.

Facility Details

Are Facility for Service and Servicing Provider the Same? Select Yes to automatically fill in the Facility details. *

Yes No

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Facility Name

Street Address

City State ZIP Code

Federal Tax ID for the Facility (9-digit number) NPI for the Facility (10-digit number)

Phone Number (if provided, must be valid phone number format) Fax Number (if provided, must be valid phone number format)

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