TRICARE® For Life Authorization Request

This form must accompany ALL records/correspondence

There are seperate forms for Skilled Nursing Facility and Mental Health. Use the form specific to your desired request.

Submit by mail, parcel or fax to:
TDEFIC - MR Authorizations
1707 W. Broadway
P.O. Box 7934
Madison, WI 53713
Fax: (608) 301-3226

Submit via email to:
TFLauthorizations@wpsic.com**
**See page 2 for requirements regarding email submissions

See Page 2 for instructions to complete this form.

Provider Information (please complete all fields)

Service Provider/Facility Name: _____

Contact Name: _____

Billing Tax ID or NPI: _____

Service Provider/Facility Address: _____

(incl. City, State, Zip Code): _____

Service Provider Telephone Number: _____ Fax Number: _____

Email Address: _____

Patient Information (please complete all fields)

TRICARE® Sponsor Number/DoD Benefit ID: _____ Sponsor Name: _____

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Patient Telephone Number: _____

Other insurance expected to pay toward service(s): ❑ Yes ❑ No Name of other insurance: _____

Requested Service Information (please complete all fields)

Start Date for Services: _____ (MM/DD/YYYY)

Requested Service Category:
(Select one of the following)

- ❑ Stem Cell/Organ Transplant
- ❑ Adjunctive Dental
- ❑ Cancer Clinical Trials
- ❑ Hospice
- ❑ ECHO (Extended Care Health Option)

Diagnosis Code: _____ Description: _____

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List additional diagnoses codes/descriptions below

Additional Information

List below additional diagnoses, procedures and/or provide additional explanation of health conditions relevant to the service authorization request (attach additional pages as needed):

_____

_____

_____

_____

_____

TRICARE® For Life Authorization Request Instructions

Requirements Regarding Email Submissions to TFLauthorizations@wpsic.com

WPS TRICARE® will only accept documents containing protected health information (PHI) and personally identifiable information (PII) through email that have been attached as password protected files to maintain the confidentiality of the sensitive information contained therein. Note that any attachments received without password protection to open will be deleted and you will receive a reply stating we cannot accept said attachments without proper security/protection.

Provider Information *Complete all fields*

- **Service Provider:** Enter the name of the individual provider who will be performing the services. If there is no individual provider enter the name of the facility where services are taking place.
- **Contact Name:** Enter the name of the person to contact for questions or requests for additional information regarding the authorization request.
- **Billing Tax ID or NPI:** Enter the billing Tax ID or the National Provider Number of the service provider or facility.
- **Service Provider/Facility Address:** Enter the street address of the service provider or facility where the services will take place.
- **Service Provider Telephone Number:** Enter the contact telephone number.
- **Fax Number:** Enter the contact fax number.
- **Email Address:** Enter the contact email address.

Patient Information *Complete all fields*

- **TRICARE® Sponsor Number/DoD Benefit ID:** Enter the policy number/plan number/sponsor number under which the patient is eligible for TRICARE® benefits.
- **Sponsor Name:** Enter the sponsor name (person enrolled in military under which the patient is eligible for TRICARE® benefits).
- **Patient Name:** Enter the name of the patient.
- **Patient Date of Birth:** Enter the date of birth of the patient (format: MM/DD/YYYY).
- **Patient Address:** Enter the patient's street address.
- **Patient Telephone Number:** Enter the patient's contact telephone number.
- **Other insurance expected to pay any amount toward the service(s):** Check Yes or No if there is another insurance paying towards the service(s). If Yes, list the name of the other insurance company.

Requested Service Information *Complete all fields*

- **Start Date for Services:** Enter the date the services will start. (format: MM/DD/YYYY)
- **Requested Service Category:** Check the box for the type of service authorization being requested.
- **Diagnosis Code:** Enter the patient's diagnosis code. (format: ICD-10)
- **Description:** Enter the description of the diagnosis code.

Attach the following additional documentation according to your request type to help expedite processing

Adjunctive Dental Service

- Other health insurance, medical or dental, paying toward the service.
- Justification for payment of dental services from a medical policy.

Stem Cell and/or Organ Transplant

- Medical documentation explaining need for transplant.

Hospice

Please note if patient is enrolled in Medicare Part A, a TRICARE® For Life authorization is not needed.

- Copy of patient's hospice election.
- Doctor's statement certifying patient has 6 months or less to live.

Cancer Clinical Trials

- Title face sheet of the protocol, including protocol number, phase and title.
- Protocol plan of treatment/schematic, consent form and calendar.
- Proof of NCI sponsorship; Designated NCI cancer center, Cooperative Group Agreement or NCI Grant.
- IRB Approval Letter specific to the trial, including date of approval stamp dated within last 365 days.
- Recent History and Physical (H&P) evaluation.

** WPS TRICARE® only issues authorizations when TRICARE® For Life is the primary payer, and when TRICARE® policy requires an authorization for the service. TRICARE® For Life does not issue retroactive authorizations for any reason. Medically necessary services are payable in the absence of an authorization by this process: Submit a claim with attached medical documentation through your established new claim submission process.

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