Phone: 1-**833-230-2170**
Fax: 937-396-3052
NICU Fax: 937-396-3499

TRICARE Prime® Demo by CareSource Military & Veterans™ Provider Prior Authorization Request Form

* Indicates Required Field

	☐ Routine* ☐ Urgent*						
Beneficiary Information							
Date of Request		Beneficiary ID Number*					
Member's Last Name*		First Name*					
Date of Birth*		Phone Number					
Beneficiary Address		City		State		ZIP	

ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

☐ Inpatient* ☐ Outpatient*									
Place of Service									
☐ Office	☐ Home	☐ Inpatient Hospital	☐ Outpatient Hospital	☐ Other					
Ordering Provider Name (First & Last Name)*									
Ord-Tax ID*		Ord-NPI*		Ord-Phone*					
Ord-Fax*									
Ord-Address*		Ord-City*		Ord-State*		Ord-ZIP*			
Service Start Date (mm/dd/yyyy)		Service End Date (mm/dd/yyyy)							
Facility/Servicing Provider Name (First & Last Name)*									
Svc-Tax ID*		Svc-NPI*							
Svc-Address*									
Svc-City*		Svc-State*		Svc-ZIP*		Fac-Phone*			
Fac-Fax*									
DX Code (1)		DX Code (2)		DX Code (3)					
Additional Information									

CPT/HCPCS

Qty*	CPT/HCPCS*	Description of Service	U&C Charge

Number of Visits					
Update Authorization Number		# of visits		Requested Extension Date	
Work/Auto/Other Insurance					
Contact Name (First & Last)*					
Contact Phone #*			Contact Fax #*		

All non-participating providers must have an authorization **prior** to services rendered. Approved prior authorization payment is contingent upon the eligibility of the member at the time of service. Services billed must be within the provider's scope of practice as determined by the applicable fee/payment schedule and the claim timely filing limits. Authorizations are not a guarantee of payment, but are based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and/or qualifications and will be determined when the claim is received for processing.