AUTHORIZATION APPEAL

Use this form to submit an appeal for a denied authorization. If you need more information about the appeals process, visit the Referrals and Pre-Authorizations page on the TRICARE website.

Submitter Information

*Required

*Relationship to Patient/Beneficiary (select one):

☐ Appointed Representative ☐ Parent or Legal Guardian ☐ Self ☐ Non-Network Participating Provider

NOTE: If you are an appointed representative, you also need to submit the completed the Appointment of Representative and Authorization to Disclose Information Form on page 3.

*Last Name:		*First Name:	
*Street Address:	*City:	*State:	*ZIP Code:
*Phone Number (XXX-XXX-XXXX):	Email Address:	*Fax Number (XXX-XXX-XXXX):	

Beneficiary Information

*Last Name:		*First Name:	
*Street Address:	*City:	*State:	*ZIP Code:
*Phone Number (XXX-XXX-XXXX):	Email Address:		
*Date of Birth (MM/DD/YYYY):	*Beneficiary DOD ID:		
*Sponsor Full Name:	*Sponsor DOD ID:		

Provider Information

*Provider Name:			
*Provider Street Address:	*City:	*State:	*ZIP Code:
*Phone Number (XXX-XXX-XXXX):	*Fax Number (XXX-XXX-XXXX):	*Provider NPI:	

*Select Provider Status: ☐ In Network ☐ Non-Network Participating ☐ Non-Network Non-Participating

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AUTHORIZATION APPEAL

Authorization Denial Information

*Have the Services Occurred? ☐ Yes ☐ No

*Type of Appeal: ☐ Routine ☐ Urgent

*Date of Service Start (MM/DD/YYYY):	*Date of Service End (MM/DD/YYYY):	*Authorization/Reference #:
*CPT, HCPC, or Description of Service or Procedure Denied:		

NOTE: Appeals must be submitted within 90 days from the date of denial. Please be sure to include the reason for the delayed appeal if this date is more than 90 days.

*Date of Denied Authorization (MM/DD/YYYY):

Issue in Dispute

*Please state the specific reason for your appeal. Briefly include the rationale for your request or the reason you believe the service should be covered.

Submit this form to the address, fax, or email below. You may send additional supporting documentation with your request.

Mail to:
TriWest Healthcare Alliance
Appeals and Reconsideration Department
P.O. Box 2636
Virginia Beach, VA 23450

Fax: 866-852-1919
Email: T5AppealsReconsideration@TriWest.com

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Appointment of Representative and Authorization to Disclose Information

This form allows a beneficiary to appoint someone to represent the beneficiary in a TRICARE appeal (32 CFR 199.10 – Appeal and Hearing Procedures). This form is not required if you are appealing on your own behalf or for a minor dependent. This appointment pertains solely to the denied authorizations or claims detailed in this form.

I appoint First Name: _____ Last Name: _____

Representative Address: _____

City: _____ State: _____ ZIP: _____

to act as my representative in connection with my appeal under 32 CFR 199.10, Appeal and Hearing Procedures. To avoid the possibility of a conflict of interest, I understand that service member or employee of the United States federal government, to include an employee or member of a Uniformed Service, an employee or staff member of a Uniformed Service legal office, a military or hospital clinic provider or a Beneficiary Counseling and Assistance Coordinator (BCAC), is not eligible to serve as a representative. An exception to this is made when an employee of the United States or member of a Uniformed Service is representing an immediate family member. I authorize the TRICARE Health Plan to release to said representative, information related to my medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for TRICARE benefits.

I understand that the representative shall have the same authority as the beneficiary to the appeal and notice given to the representative shall constitute notice to the party.

This consent will expire upon the issuance of the final agency decision regarding my appeal; however, I reserve the right to withdraw this authorization at any time.

Denied authorization numbers or claim numbers: _____

_____	_____	_____
Beneficiary Last Name	Beneficiary First Name	Sponsor SSN or DBN

_____	_____
Beneficiary Signature	Date (MM/DD/YYYY)

Prohibition on Redisclosure

Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable Federal law.

Privacy Act Statement

This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.” Violations may be punishable by fines, imprisonment, or both.

Submit Form

Return this form along with your appeal request by fax 866-852-1919, mail or email:

TriWest Healthcare Alliance
P.O. Box 2636
Virginia Beach, VA 23450

T5AppealsReconsideration@TriWest.com

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