



Alternative Referral/Authorization Form Quick Reference Guide

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.

Contents

Introduction	2
Using the Referral/Authorization Decision Support	2
Using the Alternative Referral/Authorization Form	4



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

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.

Alternative Referral/Authorization Form 1

(For use in limited cases)
This form is meant to be an alternative entry only when the Online Referral Management Tool is unavailable, or you are unable to complete the referral or authorization through the use of that tool. This form should be used in that case as an alternative to fax.

BEFORE You Submit a Request

Please use the link provided below for TRICARE® Referral and Authorization Decision Support (RADS) Tool to evaluate if an authorization or referral is required.

The link will open a new browser window.

Once you have completed the RADS tool and the results of the decision indicate whether or not an authorization is required, please return to this page to either cancel or complete your request.

2 **Click to Complete RADS tool**



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.

Referral/Authorization Decision Support (RADS) Tool Clear

- The RADS tool can be utilized to identify if healthcare services:
 - Are a TRICARE benefit
 - Require a Primary Care Manager referral
 - Require a prior authorization and medical necessity review.

The tool indicates when to send requests and/or appropriate documentation to TriWest for processing.

Beneficiary's (Patient) Plan Type:

Select One

Select One

TRICARE Prime

TRICARE Prime Remote

i The beneficiary refers to the actual patient potentially receiving care. Select that beneficiary's TRICARE plan.

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.

Beneficiary's (Patient) Plan Type:

TRICARE Prime

4

Is the beneficiary an active duty service member (ADSM)?

Yes No

Is the servicing provider in-network or non-network?

In-Network Non-Network

Place of service?

InPatient OutPatient

5

What is the service type?

Mental Health

All non-emergency Mental Health admissions require a prior authorization, continued stay and medical necessity review.

Print

6



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

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



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. Items with a black asterisk (*) indicate one of those entries is required to submit the form.

Patient Details 3

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

4. Complete the required **Sponsor Details** fields, which are denoted by a red asterisk (*), and at least one of the items denoted by a black asterisk (*).

- A. Select **Yes** to autofill the sponsor information if the sponsor and the beneficiary are the same.
- B. Select a **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

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

B Type of Service *

Outpatient Routine Outpatient Urgent Inpatient



5. Complete the required **Requesting Provider Details** fields, which are denoted by a red asterisk (*).

Requesting Provider Details

5

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

6

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

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.

Facility Details

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

Yes No

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)



9. Add attachments if applicable.

Note: Attachments must be formatted as PDFs. Also, the file name must be less than 50 characters and cannot contain special characters, such as hash tag (#), percentage sign (%), or ampersand (&).

Attachments

Add up to 30 Attachments (only PDFs will be processed). Please ensure your file name is less than 50 characters and does not contain any special characters.

Drop here or click to select

9

10. Select Submit.

Note: You will be unable to submit if required fields are blank. Complete all required fields to submit the form.

Add Attachments (only PDFs will be processed). Please ensure your file name is less than 50 characters and does not contain any special characters.

Referral-Authorization Submission.pdf

Drop here or click to select

10

Submit Cancel