



Submit/View Referrals and Authorizations User Guide

For TRICARE West Providers

Key Points

- You can access the online referral management system through the provider portal.
- You can use the online referral management system to submit referral and authorization requests, view existing referrals and authorizations, and modify existing requests that are associated with your account.
- You can search for providers using the Provider Location Search box when creating a referral or authorization request.
- To search for providers by NPI, set the ID Type to "HCFA National Provider ID." You can enter the NPI into the Other ID field.
- Wildcard characters (*) let you search for multiple key terms that start or end with the same letters. Use wildcard characters (*) to get more search results.
- Have questions that the main content didn't address? Check the Frequently Asked Questions section at the end of this user guide!



Contents

Introduction 3

Is a Referral/Authorization Required? 3

Submit a Referral or Authorization Request..... 4

Not Sure Where to Start?..... 6

Step 1: Verify Beneficiary Demographics..... 7

Step 2: Create a New Authorization..... 9

Step 3: Enter Required Fields on the Authorization Screen..... 10

Step 4: Complete the Service Tab 14

Step 5: Complete the Survey(s) or Assessment(s) 17

Step 6: Attach Relevant Documents (Recommended)..... 19

Step 7: Submit the Request 20

View Determination Letters 21

Modify Existing Authorization Requests 24

Frequently Asked Questions 27



Introduction

If a Military Treatment Facility (MTF) or the beneficiary's Primary Care Manager (PCM) cannot provide the service(s) or procedure(s) the beneficiary needs, TRICARE may require a referral or authorization so that the beneficiary can seek care with another provider. PCMs and providers can submit and modify requests for referrals and authorizations using the online referral management system on the TRICARE West Payer Space.

Note: This guide is not comprehensive of features and may be subject to change. Access the latest version of this guide from the TRICARE West Payer Space in [Availity](#).

Is a Referral/Authorization Required?

Some services require a referral or authorization depending on the beneficiary's TRICARE plan. As an example:

- **TRICARE Prime:** TriWest requires a referral from the PCM before beneficiaries can seek care from other providers.
- **TRICARE Select:** TriWest does not require referrals to seek care from TRICARE-authorized providers.

Providers can use the Referral and Authorization Decision Support (RADS) Tool to help determine when to submit online referrals and authorizations and when to provide clinical documents. Before performing services, you should access the RADS tool in Availity. Navigate to the TRICARE West Payer Space and select **Is A Referral/Auth Required?** to open the RADS tool.

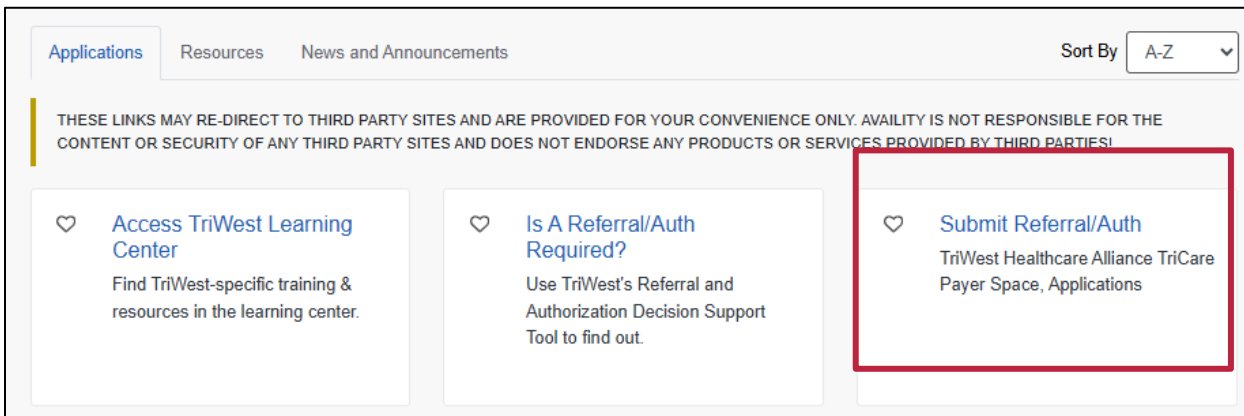
The screenshot shows the Availity application menu with the following elements:

- Navigation tabs: Applications (selected), Resources, News and Announcements.
- Sort By: A-Z (dropdown menu).
- Disclaimer: THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!
- Three application cards:
 - Access TriWest Learning Center:** Find TriWest-specific training & resources in the learning center.
 - Is A Referral/Auth Required?:** Use TriWest's Referral and Authorization Decision Support Tool to find out. (This card is highlighted with a red border in the image.)
 - Submit Referral/Auth:** TriWest Healthcare Alliance TriCare Payer Space, Applications.

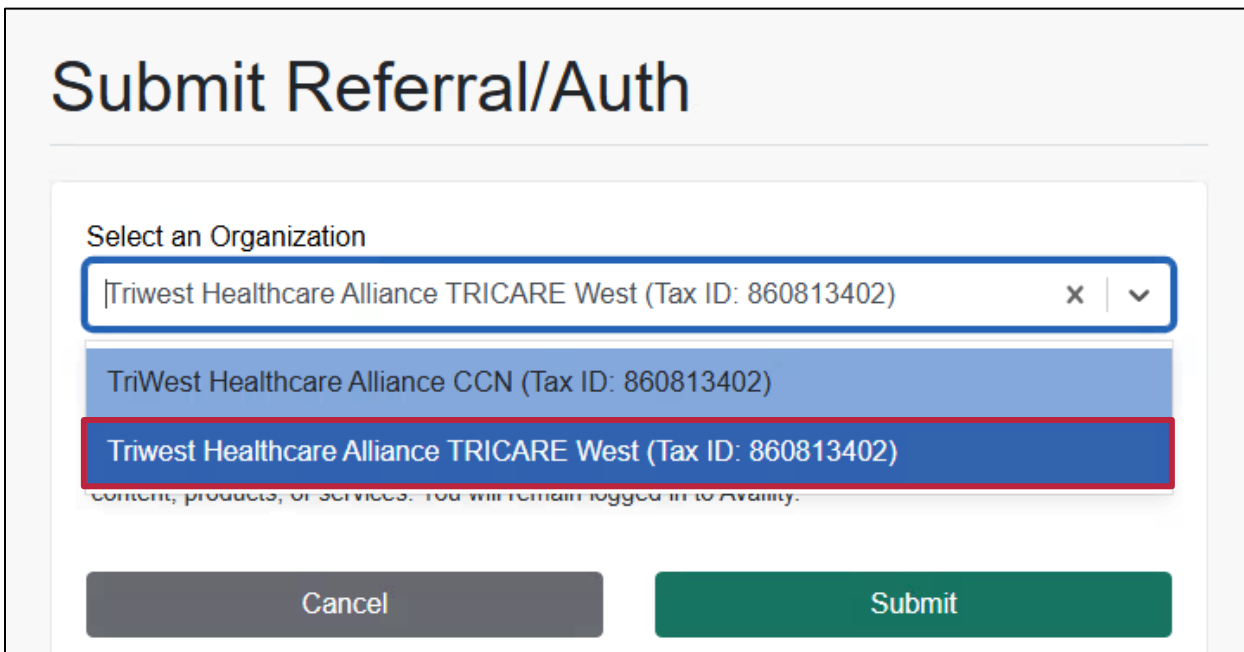


Submit a Referral or Authorization Request

If a beneficiary does require a referral or authorization, you can access the online referral management system in the Availity TRICARE West Payer Space. Log in to the provider portal and navigate to the TRICARE West Payer Space. For step-by-step instructions and images on accessing the Payer Space, refer to the [Registering and Accessing the TRICARE West Secure Provider Portal Quick Reference Guide](#). Navigate to the Applications tab, then select **Submit Referral/Auth**.



This will open the organization selection page. Select your organization from the drop-down menu, then select **Submit**. This will open the online referral management system.



To access the online referral management system, you must log in through Availity. Providers should use the referral management portal to fill out the questionnaire and submit the required clinical information.

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The PCM or requesting provider is responsible for:

- Selecting the correct TRICARE beneficiary
- Identifying the appropriate Request Type (Episode of Care profile)
- Entering the requesting provider or facility
- Identifying the specialty for the care or services the beneficiary needs
- Adding diagnosis code(s)
- Providing a reason for referral, to communicate effectively with the servicing provider if needed

In some cases, the PCM or requesting provider may also be responsible for:

- Adding procedures, to include specific Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, quantity, and type
- Entering required clinical information into a survey
- Uploading relevant clinical document attachments to support requested services or communicate information to the servicing provider

Follow the steps below to submit a referral or authorization request and attach supporting clinical information.

Note: *Attaching supporting clinical information helps reduce a request's processing time.*



Not Sure Where to Start?

1. **I can't find my patient:** Refer to Step 1, pages 7–8.
2. **I can't find a provider:** Refer to Step 3, page 12, and page 26, questions 3–4.
3. **I don't know how to modify my referral or authorization request:** Refer to pages 23–25.



Step 1: Verify Beneficiary Demographics

1. Navigate to the online referral management system home page.
2. Select the **Look Up** button. Since the fields have no information entered yet, the Member Search box will open.

The screenshot shows the CareAffiliate website interface. At the top left, the 'CareAffiliate®' logo is highlighted with a red box and a blue circle containing the number '1'. To the right of the logo are navigation links for 'Home', 'Authorizations', and 'Program Enrollment'. Below the logo is a 'Member Search' box, also highlighted with a blue circle containing the number '2'. This box contains input fields for 'Member ID' and 'Name' (with a 'format: Last, First' hint) and a 'Look Up' button. To the right of the search box is a map of the United States with the western states highlighted in blue, titled 'Welcome to TRICARE® West Region'. Below the map is a blue 'Welcome!' message box that reads: 'Welcome to the TRICARE West Region. Enter Auths in CareAffiliate for TRICARE West beneficiaries.'



- Enter the beneficiary's name into the Name field or enter their Member ID into the Member ID field. When entering the name, enter the surname first, then the given name, then the middle initial (such as "Smith, John A").

Note: Search using only one search field, not both, for best results. Searches that are too broad (terms that return more than 1000 results) may time out your search. Narrow down your search with more key terms if needed. Use the 10-digit DoD ID on the front of the ID card or the 11-digit Department of Defense Benefits Number (DBN) as the member ID. You currently cannot use an SSN as a searchable Member ID. You must enter at least five characters before you can use a wildcard character (*) in the Name field.

- Select **Search**.

Note: A wildcard character (*) helps you search for multiple key terms that may start or end with the same letters. For example, entering "Wil*" as the surname will return beneficiaries named Williams, Willis, and more as search results.

- Select the beneficiary's record from the results.

Member Search X

Member ID

Name

Birth Date

3

Search

Clear

Cancel

4

1 records matched your criteria. Please choose a record from the grid below.

Member ID	Name	Gender	Birth Date
1	WILLIAMS, FRANK	MALE	1/1/2000

5



Step 2: Create a New Authorization

1. Select **New** after the member populates.

Note: The **Member ID** label is a selectable link that shows more member details like birth date, address, plan type, and coverage dates. Additionally, submitting referrals on the online referral management system uses the same submission pages as authorizations. For example, if you want to create a new referral request, you will still select **New** on the Member Search box.

Member Search

Member ID 1

Name WILLIAMS, FRANK

Q Look Up

Search Results

[Clear](#)

▶ [Authorizations \(78\)](#)

Care Plans (0)

[Member Messages \(1\)](#)

Last Member Message(s) Received:
1/2/2025

[New](#)



Step 3: Enter Required Fields on the Authorization Screen

After you create a new authorization, you'll need to complete all required fields on the Authorization screen.

1. **Request Type:** Select the **lookup magnifying glass icon** to search for the correct Request Type (Episode of Care profile). The Request Type Selection box will open.

General Information

Member ID	1	Q
Name	WILLIAMS, FRANK	
Request Type	Begin typing to search favorites	Q



- A. Enter search terms into the fields as needed. You can use keywords, and a wildcard character (*) before and/or after keywords, to narrow the result list.
- B. Select **Search**.
Note: If the Request Type you need doesn't appear, either select the closest Episode of Care profile, select EVAL & TREAT (if requesting a service) as the Request Type, or select OUTPATIENT MEDICAL AND TREAT (if requesting anything but a service) as the Request Type. If you select EVAL & TREAT or OUTPATIENT MEDICAL AND TREAT as the Request Type, you will need to manually list the appropriate Current Procedural Terminology (CPT) codes your request needs in the Service tab.
- C. Select a Request Type from the results. The Request Type will now apply to your request. You'll return to the original Authorization page. After selecting the Request Type, the screen expands to include the Diagnoses, Services, Survey and Attachments sections. You can now complete the sections following General Information.
Note: Fields with the watermark text "Begin typing to search favorites" will remember the terms you enter for later searches. As you use the online referral management system, the system remembers your commonly used Request Types, codes, providers, and more.

Request Type Selection X

Request Type Description

Containing Procedure

Containing Specialty

Show Inpatient Only

Show Behavioral Health / Substance Abuse only

Search
Clear
Cancel

176 records matched your criteria. Please choose a record from the grid below.

Code	Description	Details
ADSM_TL	ADSM Terminal Leave	Used for requests for terminal leave for Active Duty Service Members (ADSM). This request is to be used by military hospitals or clinics only.
FIT_FOR_DUTY	ADSM physical and mental assessment	for medical assessment process to de-terminine if ADSM is physically and mentally capable of performing their military duties.
ABORT	Abortion	Abortions have limited coverage. A survey is required with submission



2. **Contact Name:** This field should automatically fill in based on your profile on the provider portal. If nothing appears in this field, enter the contact's name.
3. **Contact Phone:** Enter the contact number.
4. **Requesting Provider/Facility:** Use the **lookup icon** to search for and select the provider or facility. The Provider Location Search box will open.

The screenshot shows a 'Requester' form with the following fields and callouts:

- 2:** Callout pointing to the 'Contact Name' field.
- 3:** Callout pointing to the 'Contact Phone' field.
- 4:** Callout pointing to the 'Requesting Provider/Facility' search field, which includes a magnifying glass icon.

Other fields include 'Requesting Group' with a search icon and a checkbox for 'Default for all Requested Services'.

- A. Enter either a provider's name (formatted "Last, First*") or a facility's name in the Name field. Provider name searches require a wildcard character (*) and a comma (such as "Smith, John*"). Facility or group names don't require a comma, and wildcard characters (*) are optional but recommended.

Note: You can search by just the provider's last name, but you must enter at least five characters before you can use a wildcard character (*). You can also search by the Health Care Financing Administration (HCFA) National Provider Identifier (NPI). Enter the NPI into the Other ID field. Then, select "HCFA National Provider Identifier" as the type in the ID Type field.

- B. Select **Search**. If the provider doesn't appear, refer to **Frequently Asked Questions**.
- C. Select a location from the results.

The screenshot shows the 'Provider Location Search' dialog box with the following fields and callouts:

- A:** Callout pointing to the 'Name' field, which contains the text 'Last, First*'.
- B:** Callout pointing to the 'Search' button.
- C:** Callout pointing to the results table at the bottom.

The results table has the following columns: Provider ID, Provider Name, Group Name, Street Address, City, State, Postal Code, and Contract. The current message in the table is 'there are no records to display.'



- 5. Requesting Group:** If you selected a provider in the Requesting Provider/Facility field, this field displays the requesting group automatically. No entry is required. If you can't find your provider with the Requesting Provider/Facility field, select the **lookup icon** next to Requesting Group instead. This will open the Provider Location Search box; refer to steps **4A-4C** to learn how to use the Provider Location Search box. When searching by group, you will need to set the ID Type to "GROUP HCFA National Provider Identifier" instead of "HCFA National Provider Identifier."

Note: If the provider's demographic information (such as address, phone, or fax number) is listed incorrectly or is not present, you may add or edit this information for a specific authorization. To make the change, select either the Requesting Provider/Facility field or the Requesting Group field. After the "Provider Affiliation Details" window appears, select Edit and then select OK.

6. Select the **Default for all Requested Services** checkbox if you want to use the same contact and provider information for all services associated with the request.

The screenshot shows the 'Requester' form with the following fields and callouts:

- Contact Name:** Text input field.
- Contact Phone:** Text input field.
- Requesting Provider/Facility:** Search field with placeholder text 'Begin typing to search favorites' and a magnifying glass icon. A blue callout circle with the number '5' is positioned to its right.
- Requesting Group:** Search field with placeholder text 'Begin typing to search favorites' and a magnifying glass icon.
- Default for all Requested Services:** A checkbox with the label 'Default for all Requested Services'. A blue callout circle with the number '6' is positioned to its right.

7. Enter the appropriate diagnosis code in the fields. You must enter at least one diagnosis code. **Note:** Once you've entered a code, select **Tab** on your keyboard to automatically populate its Description field. You can use wildcard characters (*) while entering search terms for diagnosis codes. For this field, there is no minimum character limit before you can use a wildcard character (*).

The screenshot shows the 'Diagnoses' table with the following structure:

Diagnosis	ICD10	F41.1	Generalized anxiety d	🔍
Diagnosis		Code	Description	🔍
Diagnosis		Code	Description	🔍
Diagnosis		Code	Description	🔍

A blue callout circle with the number '7' is positioned to the right of the first row.



Step 4: Complete the Service Tab

1. Navigate to the **Service** tab.

Note: The Service(s) total and default procedures included will vary based on the Request Type (Episode of Care profile). Please complete all default Service tabs presented based on Request Type.

2. Review the **Service From** and **To** fields. These may auto-populate with a default duration based on the Request Type used. Adjust the dates if necessary.

3. Fill in the servicing provider fields. You must provide a servicing Provider Specialty. If you need to make a directed referral, you must also enter either the Provider, Group, or Facility.

Note: The Provider, Group, and Facility fields have lookup icons. Selecting the icons brings up the Provider Location Search box, as shown in **Step 3: Enter Required Fields on the Authorization Screen**.

4. Review the **Procedure Information** section. Some Request Types will automatically choose the allowed lines and procedures. For these Request Type, you can't enter additional lines or services. Other Request Types will let you add additional service lines or CPT codes as needed. **Do not delete the default CPT codes, such as office visits, which appear with your Request Type automatically.**

Note: Servicing providers are not required to bill for office visits if the beneficiary does not use those visits.

Service #1 - Medical Care

Copy Service Line Add New Service Line Delete Service Line

Authorization Request

1

Service 1
On Campus - Outpatient
Hospital/
Medical Care

Service 2
On Campus - Outpatient
Hospital/
Medical Care

Service 3
On Campus - Outpatient
Hospital/
Medical Care

Attachments (0)

Status Reason Auto-pro
Place of Service On Cam Hospital 2

Service From 01/29/2025
To 03/30/2026

3

Provider
Group
Facility
Provider Specialty Internal Medicine- Medical Oncology
Disposition (None)

Procedure Information

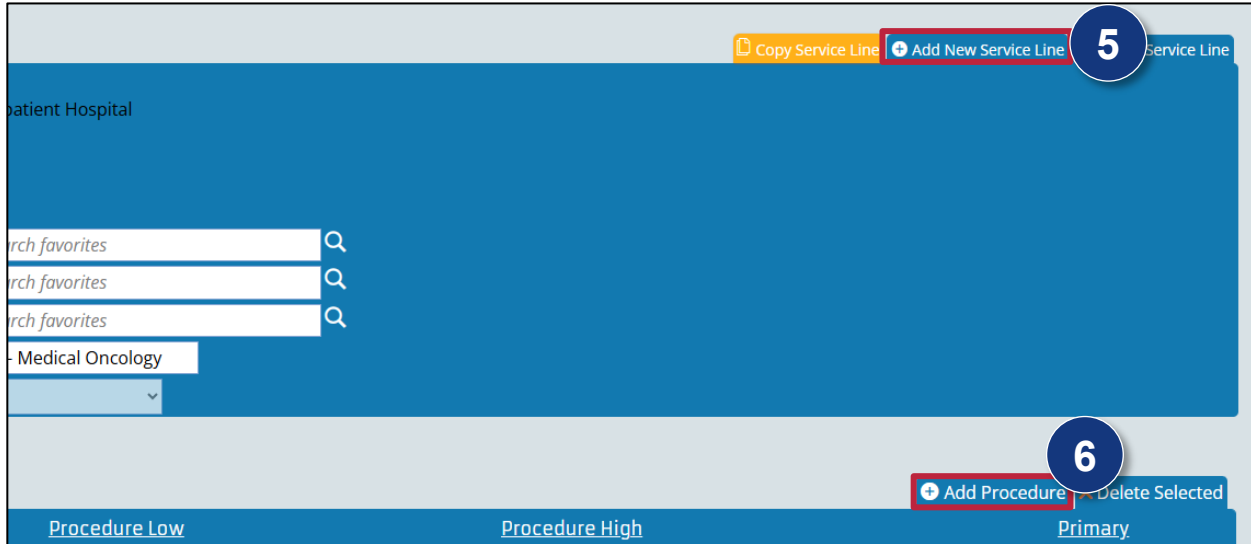
Add Procedure Delete

Type	Procedure Low	Procedure High	Primary
<input type="checkbox"/> Edit	CPT 99242 - off/op constlj new/est sf 20	99245 - off/op constlj new/est hi 55	<input checked="" type="checkbox"/>
<input type="checkbox"/> Edit	CPT 99202 - office o/p new sf 15 min	99205 - office o/p new hi 60 min	
<input type="checkbox"/> Edit	CPT 99211 - off/op est may x req phy/ghp	99215 - office o/p est hi 40 min	

4



5. Select **Add New Service Line** to add a service line if needed. You can add a maximum of 10 lines or procedures per Service tab. Keep in mind that not all Request Types will allow you to add new service lines.
Note: *If you want to copy the Place of Service and Service fields from an existing line to the new line, select **Copy Service Line** instead.*
6. Select **Add Procedure** if you need to add any additional procedures. The Add Procedure box opens.





- A. Complete the required fields. Use the **Procedure Low** and **Procedure High** fields to help you search for the CPT codes you need.
Note: You can use the Procedure Low and Procedure High fields to enter ranges for codes, or you can use the same code for both fields. You can also use wildcard characters () while entering search terms for procedures. For this box, there is no minimum character limit before you can use a wildcard character (*).*
- B. Select **Add**. The procedure is displayed in the Procedure Information section.



Step 5: Complete the Survey(s) or Assessment(s)

Some Request Types (Episode of Care profile) may require you to complete a survey or assessment before proceeding. This does not apply to all referrals/authorization requests.

1. Review the Authorization Request panel for a Survey or Assessment section. If an **Assessment** tab appears, you can use it to suggest updates to patient and provider information, as well as give reasoning if your request needs a non-network provider. If no section for either appears, your Request Type does not require one—proceed to **Step 6: Attach Relevant Documentation (Recommended)**.
2. Select the **Survey** or **Assessment** tab.
3. Select **Launch Survey** or Launch Assessment depending on type.

The screenshot shows a web interface for a 'Survey' section. On the left, there is a sidebar with a red box around the 'Survey' tab, labeled with a '1'. The sidebar also includes 'Authorization Request', 'Service 1 Office/Medical Care', and 'Service 2 On Campus - Outpatient Hospital/Medical Care'. Below the sidebar, the 'Survey' tab is selected and labeled with a '2'. The main content area has a blue header with the text 'To complete a [redacted] survey or perform a new one, click the "Launch Survey" button below.' and a 'Launch Survey' button labeled with a '3'. Below this, it says 'There are (1) Active Surveys.' and a table with columns 'Survey Name' and 'Date/Time Initiated'. The table content is 'There are no records to display.'



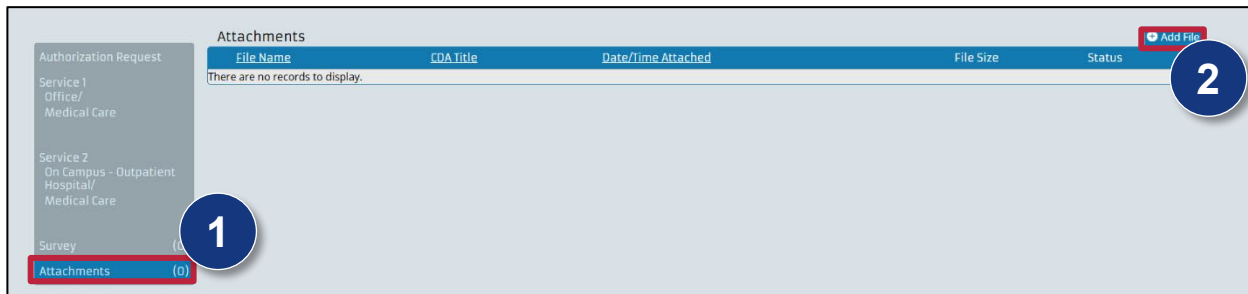
4. Complete all required questions, as well as all optional questions as appropriate.
5. Navigate back to the top of the page once done.
6. Select **Done**.

The screenshot shows a web-based survey interface. At the top, there is a blue header with the word "Survey" and a close button. Below the header, the survey title "Medical Oncology Screening" is displayed. In the top right corner of the survey area, there are three buttons: "Done" (highlighted with a blue circle containing the number 6), "Postpone", and "Cancel". A "NOT MET" button is also visible. The main content area is titled "1. Section 1: Medical Oncology Care Screening" and contains two questions. Question 1 asks for the "requested treatment start date" and includes a date picker. Question 2 asks for "CPT/ HCPCS codes" and includes a large text input area. A blue circle with the number 4 is positioned over the text input area for question 2.

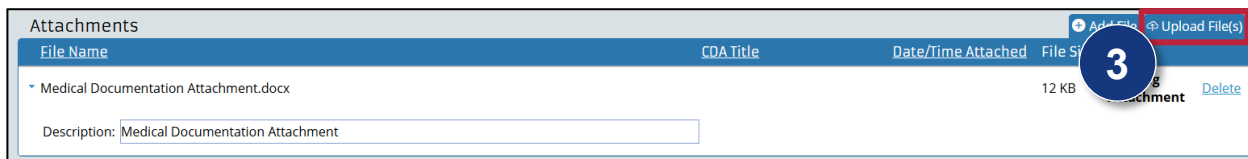


Step 6: Attach Relevant Documents (Recommended)

1. Navigate to the **Attachments** tab if you need to include any relevant documents, such as labs, proof of medical necessity, patient history, and/or imaging. You can only attach .pdf files.
2. Select **Add File** to start adding documents.
Note: If no attachments are necessary, skip this step and step 3.



3. Select **Upload Files** once done.





Step 7: Submit the Request

1. Select **Submit** after entering all information.

Note: After TriWest approves or denies the referral or authorization, they will send a notification to the beneficiary and referring providers/PCM. Some requests may receive approval instantly, but for requests that require medical review or that add supporting attachments, they will receive a determination in two to five days.

Once submitted, the beneficiary's record updates to display the authorization. You will also receive a reference number for the request. You can check the request's status on their record. Use the Record Search described in **Modify Existing Authorization Requests** to find their record and check back on your request status any time.

- A. **Certified** means your request was fully approved.

Service #1 - Consultation (Certified-Post Automation)

- B. **Modified** means that either some, but not all, lines of your request were approved, or all services were approved but with modifications. Some modifications may include simple demographic updates, such as a phone number or address. Check your request for further details. Your request is still considered approved, so you don't need to take any further action; you may proceed with your referral or authorization.

Service #1 - Medical Care (Modified-Post Automation)

- C. **Not Certified** means your request was denied. Refer to **View Determination Letter** for more information.

Service #1 - Medical Care (Not Certified-Post Automation)

- D. **Pended** means your referral or authorization is in progress.

Service #1 - Pended

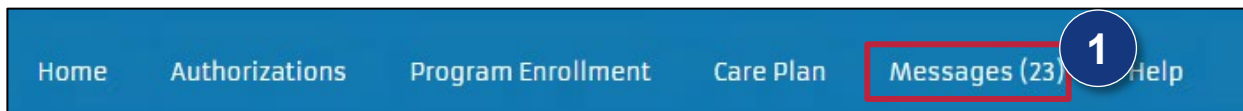
For additional information, select the **Help** link in the online referral management system. For step-by-step training, review the online referral management system training available within [Availity](#).



View Determination Letters

If your request receives a denial and the Not Certified status, you should review your determination letter for the denial reason and next steps. You can access the determination letter from the online referral management system.

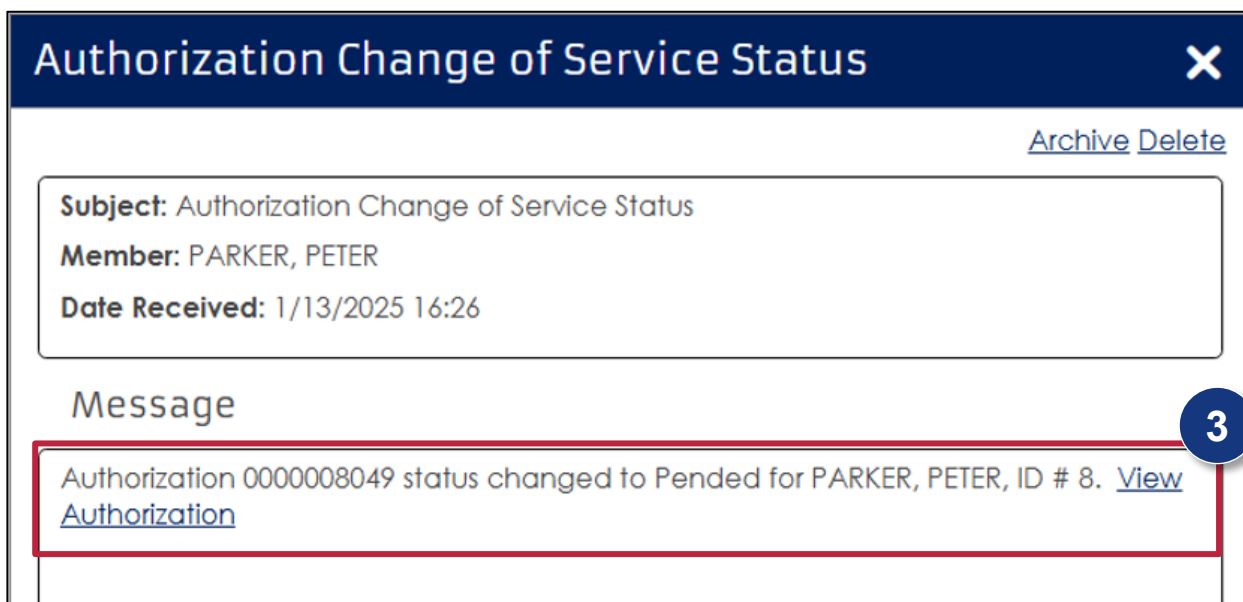
1. Select **Messages** from the site ribbon. The Messages page will open.



2. Locate and select the authorization request you want to view. The Status box opens.

<input type="checkbox"/>	Authorization Change of Service Status	12/31/2024 22:22	Authorization 0000004584 status changed to Canceled for HOPPINSON, MISS, ID # HOPP1234.	2
<input checked="" type="checkbox"/>	Authorization Change of Service Status	12/31/2024 22:21	Authorization 0000005839 status changed to Not Certified for HOPPINSON, MISS, ID # HOPP1234.	
<input type="checkbox"/>	Authorization Change of Service Status	12/31/2024 19:35	Authorization 0000005839 status changed to No Action Required for HOPPINSON, MISS, ID # HOPP1234.	

3. Select **View Authorization**. The Authorization Request page opens.





4. Select **Attachments**.

Service 1 - (Not Certified-Post Automation) Office/ Consultation	
Assessment	(0)
Attachments	(2)



5. Locate and select the determination letter hyperlink.

<p>Authorization Request</p> <p>Service 1 - (Not Certified-Post Automation) Office/ Consultation</p> <p>Assessment (0)</p>	<p>File Name</p> <p>https://sadoctdevt2wus3.file.core.windows.net/uploads/UM4000 - Authorization Determination Letter_7585.pdf-UM4000 - Authorization Determination Letter</p> <p>Description: <input type="text"/></p> <p>5</p> <p>UM4000 - Authorization Determination Letter</p> <p>Description: <input type="text"/></p>
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Modify Existing Authorization Requests

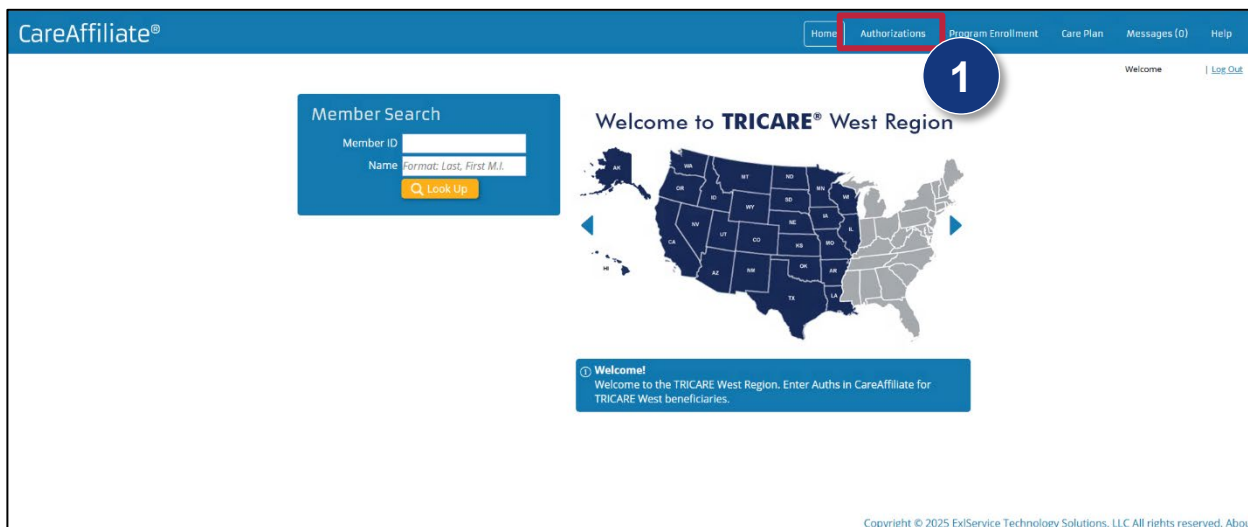
You can also use the online referral management system to modify existing authorization requests.

Only the referring provider can change their own requests. You can make as many changes as you need to a request if patient hasn't received the service yet. Referring providers cannot update requests if the patient has already received the service.

Approved referred providers can submit referrals or authorizations for any additional codes needed. If the original authorization expires during treatment, the PCM must request a new authorization. Include notes for continuity of care if needed.

You can view the authorization record using the steps outlined in **View Determination Letters**, but this section will cover how to search for records manually.

1. Select Authorizations from the online referral management system home page.





- Enter appropriate search terms into the Search Criteria fields. For best results, search with an NPI in the **Requesting Provider ID** or **Servicing Provider ID** fields. If the provider still doesn't appear, try entering the NPI into the **Requesting Group ID** or **Servicing Group ID** fields.
Note: Avoid entering too many search terms at the start, as your search may return no results if too narrow.
- Select **Search Existing Records**.

- Select the appropriate authorization record from the results.

Reference #	Authorization #	Member ID	Member Name	Member DOB	Status	Diagnosis
0000000076		1	WILLIAMS, FRANK	01/01/2000	Not Certified	A28.1 : Cat-scratch disease
0000000078		1	WILLIAMS, FRANK	01/01/2000	Not Certified	K35 : Acute appendicitis
0000000073		1	WILLIAMS, FRANK	01/01/2000	Not Certified	A28.1 : Cat-scratch disease

- Select **Edit** to modify fields.

25 years · Reference # 0000000073 · (Not Certified)

General Information

Member ID 1
Name WILLIAMS, FRANK
Request Type Inpatient Surgical



- 6. Edit or add services, notes, and attachments on the Authorization Request, Service, or Attachment tabs.
- 7. Select **Submit** once done.
Note: You cannot edit the following fields after submitting a request: Place of Service, Service, Status Reason, Length of Stay.

Home Authorizations Program Enrollment Care Plan Messages (23) Help

Welcome [User Name] Log Out

5 years · Reference # 0000000073 · (Not Certified) [Submit](#) [Cancel](#)

Service #1 - Surgical (Not Certified-Post Automation) [Copy Service Line](#)

6

Status Reason	Not Eligible for TRICARE	
Place of Service	Inpatient Hospital	
Service	Surgical	
Service From	11/14/2022	
Facility	8888GENHCF - FACILITY, GENERIC	
Actual Date Admitted	<input type="text"/>	
Admitting Diagnosis	<input type="text"/> Code	<input type="text"/> Description <input type="button" value="Q"/>
Actual Discharge Date	<input type="text"/>	
Discharge Diagnosis	<input type="text"/> Code	<input type="text"/> Description <input type="button" value="Q"/>



Frequently Asked Questions

1. **A provider has more than one address listed in the online referral management system. What happens if I select the incorrect address? Will my referral or authorization automatically receive a denial?**
 - No, the chosen provider address does not play a role in the referral and authorization determination. Selecting the incorrect address may prompt a review if the beneficiary does not have continuity of care (COC) with the provider before the request is approved or redirected.
 - Please note that if you cannot find the address you need, you can enter it manually. This change will only be made for the current authorization that is being requested and will not be a permanent change/addition in the system.
2. **What does the text next to the reference number on a referral or authorization mean?**
 - This is the request status. Refer to **Step 7: Submit the Request** for more information.
3. **How do I search for providers in the online referral management system? How do I search for a provider using their NPI?**
 - You can search for providers with the Provider Location Search box. Refer to page 10 for more information on accessing the box. To search with an NPI, enter the NPI into the Other ID field. Select the ID Type field and set it to HCFA National Provider ID.
4. **How do I troubleshoot finding the provider I am looking for using the Search function?**
 - Ensure you are formatting the names correctly. The search will return more results if you enter the surname first, then the given name and middle initial (such as "Smith, John A"). You can also use a wildcard character (*) to search for words that start or end with the same set of letters.
 - Searches that are too broad (terms that return more than 1000 results) may time out your search. Narrow down your search with more key terms if needed.
 - Uncheck the "Contract Only" checkbox. Leaving this checked may limit your search results.
 - If you are searching for a provider from existing records and they do not display, that may mean the provider has no existing authorizations entered in the online referral management system at the time of your search. All in-network providers will display when you are searching for a provider from a new authorization request.
 - The provider you're looking for may be classified as a group. Try using search options for group providers or group IDs (such as using **Requesting Group** instead of **Requesting Provider/Facility** when opening the Provider Location Search).



5. Does the online referral management system show how many visits are authorized for an approved request?

- Navigate to the Service tab on a request. In the Procedure Information section, select the drop-down arrow on any row. This will open the Procedure Details section, where you can view the Quantity.

Procedure Information				
	Type	Procedure Low	Procedure High	Primary
<input type="checkbox"/>	Edit	99242 - off/op constlj new/est sf 20	99245 - off/op constlj new/est hi 55	<input checked="" type="checkbox"/>
Procedure Details Quantity: 1 - Visits				
<input type="checkbox"/>	Edit	99202 - office o/p new sf 15 min	99205 - office o/p new hi 60 min	
Procedure Details Quantity: 1 - Visits				
<input type="checkbox"/>	Edit	99211 - off/op est may x req phy/qhp	99215 - office o/p est hi 40 min	
Procedure Details Quantity: 10 - Visits				

6. How can I check a beneficiary's coverage details?

- You can check this from their Member Details profile.
- A. Enter the beneficiary's name and member ID into the Member Search fields. Refer to **Section 1: Verify Beneficiary Details** for more information on Member Search. Once you've entered the information, the Member ID hyperlink will appear.
- B. Select the **Member ID** hyperlink. The Member Details profile will open.

Member Search

B Member ID 200 **A**

Name DOUGHNUT, JOEY

Q Look Up



C. Review the listed coverage and coverage dates.

Member Details
X

Member DOUGHNUT, JOEY

Date of Birth 3/4/1991

Sex at Birth MALE

Gender Identity None

Preferred Pronouns None

Sexual Orientation None

Alias / Preferred Name

Address 125 BOULDER DRIVE
GLENDALE, AZ 85308

Coverage 311 - TRICARE Prime-
Active Duty Family
Members

Coverage Dates 12/1/2022 - (None)

7. **What do I do if I need to modify an unchangeable field on my request, such as the Place of Service, Service, Status Reason, or Length of Stay fields?**
 - You will need to submit a new referral or authorization request.
8. **What if I don't know the exact diagnosis codes I need to add? Can I search for codes in the tool?**
 - Selecting the **lookup icon** next to the diagnosis code fields. This will open the Diagnosis Search box, which you can use to search for codes. Use wildcard characters (*) when entering terms into the Description field for best results.



Diagnosis Search
✕

Code Type

Code

Description

Gender

Age

Type	Code	Description	Gender	Min Age	Max Age
There are no records to display.					

9. I can't view or edit an authorization or referral I made, even though I can receive notifications in the Message Center about the authorization or referral. Why did my permissions change?

- Check the provider portal to ensure you've selected the correct organization. You should always select the organization you intend to submit, view, and modify TRICARE referrals and authorizations from. If you have selected another organization, you may not be able to view or edit your TRICARE referrals and authorizations.
- Check the provider portal to ensure your listed Provider ID is correct.

10. Does TriWest accept retroactive authorizations?

- Yes, TriWest will accept retroactive authorizations if the service was within waiver time, extending back to January 1, 2025.

11. Do I need to provide letters of attestation when submitting referral or authorization requests?

- No, letters of attestation are not required.

12. Where can I learn more about referrals and authorizations?

- Visit the TriWest Learning Center and the Resources tab. You can access both from the TRICARE West Payer Space.