

**Service requests should be submitted directly by registered providers at UHCMilitaryWest.com.
Use this form only if online option is not available.**

Admission Type:

- ER
 Direct Admit
 Elective

Fax complete form to UnitedHealthcare Military & Veterans at:

- 877-890-9309 Routine
 877-890-8203 Urgent (*Care needed within 72 hours*)
 877-578-2738 Inpatient

Anticipated Date of Service: _____

Service Type: (Check one) Specialty Referral Inpatient (Acute, SNF, or Rehab)
 Outpatient (Medical/Surgical/Home Health) DME

Beneficiary Information (Completion of **ALL** fields is **REQUIRED**)

Last Name:		First Name:		MI:	Gender:	DOB: (mm/dd/yyyy)	
Address: Street:			Apt.:	City:		State:	ZIP Code:
Contact Phone:		<input type="checkbox"/> Sponsor SSN OR <input type="checkbox"/> DoD Benefits Number (found on <i>back</i> of ID card):					

Diagnostic Information
(REQUIRED FOR ALL REQUESTS: Diagnosis codes; Episode of Care Name and/or CPT Codes; Reason for Requested Service)

Diagnoses (ICD Code(s)):				Diagnosis Description:			
Episode of Care: <small>Use exact name from UHCMilitaryWest.com > Referrals and Prior Authorizations > Episode of Care (EOC) Table</small>				Reason for Requested Service. Attach clinical notes**.			
CPT 4 Code(s) / HCPCS Code(s):	# of Units:	CPT 4 Code(s) / HCPCS Code(s):	# of Units:				
**Attaching clinical notes provides sufficient information for military treatment facility review and supports medical necessity review if needed.							

Requesting Provider Information (Do not use group name) (Completion of **ALL** fields is **REQUIRED**)

Last Name:		First Name:		NPI #:	
Address: Street:		Suite:	City:		State: ZIP Code:
Office Phone:			Office Fax:		
Contact Name:			Contact Department:		

Servicing Provider (Check One) Physician Facility Agency Vendor

Last Name or Entity Name (Required):		First Name (Required for Physician):		<input type="checkbox"/> NPI <input type="checkbox"/> TIN	
Address (Required): Street:		Suite:	City:		State: ZIP Code:
Specialty (Required):		Office Phone:		Office Fax:	

Servicing Facility (Required if applicable) (Check One) Acute Inpatient Outpatient Skilled Nursing Observation Rehabilitation

Facility Name:		<input type="checkbox"/> NPI <input type="checkbox"/> TIN			
Address: Street:		Suite:	City:		State: ZIP Code:
Office Phone:			Office Fax:		

TRICARE West Region Customer Service: 1-877-988-9378 (WEST) For medical inpatient services ask your representative to be transferred to our intake specialists. This document may contain personally identifiable information, including protected health information. Only those with a need to know should access or use this document. Access, use or disclosure of this document or its contents must comply with the MHS Notice of Privacy Practices, the HIPAA Privacy Rule and the DoD Privacy Program. If you received this document in error, please contact us immediately at 1-877-988-9378.

TRICARE is a registered trademark of the Defense Health Agency. All rights reserved. The Military Treatment Facility (MTF) in your area may have Right of First Refusal for this service. Behavioral health request forms can be found at UHCMilitaryWest.com > Providers > Find a Form.