UnitedHealthcare MILITARY & VETERANS

Referral/Authorization Request Form

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 ☐ Outpatient (Medical/Surgical/Home Health) ☐ Inpatient (Acute, SNF, or Rehab) ☐ 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:

☐ Sponsor SSN OR

☐ DoD Benefits Number (found on *back* 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:

Use exact name from UHCMilitaryWest.com > Referrals and Prior Authorizations > Episode of Care (EOC) Table

CPT 4 Code(s) / HCPCS Code(s):	# of Units:	CPT 4 Code(s) / HCPCS Code(s):	# of Units:

Reason for Requested Service. Attach clinical notes**.

**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):**	☐ NPI ☐ 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:	☐ NPI ☐ 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.

Behavioral health request forms can be found at UHCMilitaryWest.com > Providers > Find a Form.