TRICARE® For Life Authorization Request

SKILLED NURSING FACILITY

This form must accompany ALL records/correspondence

Submit by mail, parcel or fax to:
TDEFIC - MR SNF Authorizations
1707 W. Broadway
P.O. Box 7934
Madison, WI 53713
Fax: (608) 301-3226

Submit via email to:
snfauthorizations@wpsic.com**
***See page 2 for requirements regarding email submissions*

Submit an online form at:
www.TRICARE4u.com

See Page 2 for instructions to complete this form.

Provider Information (please complete all fields)

Service Provider/Facility Name: _____

Contact Name: _____

Billing Tax ID or NPI: _____

Service Provider/Facility Address: _____

(incl. City, State, Zip Code): _____

Service Provider Telephone Number: _____ Fax Number: _____

Email Address: _____

Patient Information (please complete all fields)

TRICARE® Sponsor Number/DoD Benefit ID: _____ Sponsor Name: _____

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____ (optional)

Patient Telephone Number: _____

Other insurance expected to pay toward service(s): ❑ Yes ❑ No Name of other insurance: _____

Requested Service Information (please complete all fields)

******Authorizations must be obtained prior to the start of service******

3 Day Qualifying Hospital Stay Dates: _____ (MM/DD/YYY)

Medicare/Other Insurance Exhaust Date: _____ (MM/DD/YYY)

Start Date for TRICARE® Authorization: _____ (MM/DD/YYY)

Diagnosis Code: _____ Description: _____ (optional)

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Additional Information

You must attach the last 4 weeks of the following documentation to help eliminate delays in processing your request:

History and Physical (H&P) from Hospital
Discharge Summary from recent acute care stay
MD Orders
MD Progress Notes
Minimum Data Set (MDS) Assessment (most recent)
Nurses Notes (daily narratives)
Wound Care: measurement, treatment, where acquired, etc.
PT Evaluations/Time Logs/Weekly Progress Notes
OT Evaluations/Time Logs/Weekly Progress Notes
ST Evaluations/Time Logs/Weekly Progress Notes
RT Documentation

Skilled Nursing Facility Authorization Request Instructions

Requirements Regarding Email Submissions to snfauthorizations@wpsic.com

WPS TRICARE® will only accept documents containing protected health information (PHI) and personally identifiable information (PII) through email that have been attached as password protected files to maintain the confidentiality of the sensitive information contained therein. Note that any attachments received without password protection to open will be deleted and you will receive a reply stating we cannot accept said attachments without proper security/protection.

Provider Information *Complete all fields*

- **Service Provider:** Enter the name of the individual provider who will be performing the services. If there is no individual provider enter the name of the facility where services are taking place.
- **Contact Name:** Enter the name of the person to contact for questions or requests for additional information regarding the authorization request.
- **Billing Tax ID or NPI:** Enter the billing Tax ID or the National Provider Number of the service provider or facility.
- **Service Provider/Facility Address:** Enter the street address of the service provider or facility where the services will take place.
- **Service Provider Telephone Number (incl. Ext.):** Enter the contact telephone number. Include an extension number if needed, to reach the contact.
- **Fax Number:** Enter the contact fax number.
- **Email Address:** Enter the contact email address.

Patient Information *Complete all fields*

- **TRICARE® Sponsor Number/DoD Benefit ID:** Enter the policy number/plan number/sponsor number under which the patient is eligible for TRICARE® benefits.
- **Sponsor Name:** Enter the sponsor name (person enrolled in military under which the patient is eligible for TRICARE® benefits).
- **Patient Name:** Enter the name of the patient.
- **Patient Date of Birth:** Enter the date of birth of the patient (format: MM/DD/YYYY).
- **Patient Address:** Enter the patient's street address.
- **Patient Telephone Number:** Enter the patient's contact telephone number.
- **Other insurance expected to pay any amount toward the service(s):** Check Yes or No if there is another insurance paying towards the service(s). If Yes, list the name of the other insurance company.

Requested Service Information *Complete all fields*

- **3 Day Qualifying Hospital Stay Dates:** Enter the qualifying hospital stay dates. Day of discharge does not count toward qualifying stay. (format: MM/DD/YYYY - MM/DD/YYYY)
- **Medicare/Other Insurance Exhaust Date:** Enter the date Medicare/Other Insurance skilled nursing benefit coverage exhausts. (format: MM/DD/YYYY - MM/DD/YYYY)
- **Start Date for TRICARE® Authorization:** Enter the expected date for the start of the TRICARE® Authorization. (format: MM/DD/YYYY - MM/DD/YYYY)
- **Estimated Length of Stay in Days:** Enter the estimated number of days the patient will stay in skilled nursing facility care. Requests can be for no more than 30 days maximum.
- **Diagnosis Code:** Enter the patient's diagnosis code. (format: ICD-9/ICD-10)
- **Description:** Enter the description of the patient's diagnosis code. (optional)

** WPS TRICARE® only issues authorizations when TRICARE® For Life is the primary payer, and when TRICARE® policy requires an authorization for the service. TRICARE® For Life does not issue retroactive authorizations for any reason. Medically necessary services are payable in the absence of an authorization by this process: Submit a claim with attached medical documentation through your established new claim submission process.