TRICARE® Referrals and Prior Authorizations

Referrals

A referral is the process of sending a patient to another provider for services or consultation that the referring source believes is outside their scope of practice and is not prepared or qualified to provide. Referral requirements are based on the beneficiary’s TRICARE program option (e.g., TRICARE Prime or TRICARE Standard). The initial consult is valid for 90 days. Follow-up visits are valid up to 180 days for the number of visits specified. See Section 6 and 7 of the TRICARE North Region Provider Handbook for additional referral requirements.

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<tr>
<th>Referral Requirements by Beneficiary Category</th>
<th>Health Net Referral Requirements</th>
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<tr>
<td>Coordinate specialty care referrals based on the following guidelines:</td>
<td>• Civilian providers can use the Prior Authorization, Referral and Benefit Tool, located at <a href="http://www.hnfs.com">www.hnfs.com</a>, to determine if a Health Net referral is required. If a referral is required, Health Net will also confirm whether the MTF offers the specialty service being requested and determine its ability to accept the patient before care is referred to the civilian network.</td>
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<td>• Active Duty Service Members (ADSMs): ADSMs, including those enrolled in TRICARE Prime Remote (TPR), always require a referral from Health Net Federal Services, LLC (Health Net) for civilian (network or non-network) provider specialty care.</td>
<td>• Prior authorization may be required for specific outpatient and inpatient services.</td>
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<td>• TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members Beneficiaries: Must coordinate referrals through their primary care manager (PCM) to network specialty care providers, except for emergency care, preventive care services from network providers, the eight initial outpatient behavioral health care visits to network providers or when they choose to use the point of service (POS) option.</td>
<td>• The following exception applies to the requirement for referrals to be coordinated through the PCM: If a pediatric patient age 5 or younger or a patient with a developmental, mental or physical disability requires general anesthesia for a non-covered dental procedure, the request for prior authorization may be submitted by the dentist.</td>
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<td>• TRICARE Standard, TRICARE Retired Reserve and TRICARE Reserve Select Beneficiaries: Do not require a referral from Health Net and may self-refer to TRICARE-authorized providers.</td>
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<td>• TRICARE For Life and Dual-eligible Beneficiaries: Do not require a referral.</td>
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<td>• TRICARE Beneficiaries with Other Health Insurance (OHI): Beneficiaries (excluding ADSMs) with OHI that is primary to TRICARE may self-refer to TRICARE-authorized providers.</td>
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Prior Authorizations

Prior authorization is the process of reviewing certain medical, surgical and behavioral health care services to ensure medical or psychological necessity and appropriateness of care. Prior authorization must be submitted to Health Net prior to services being rendered. Prior authorizations for medical or surgical services will have a begin date and an end date. Prior authorizations for behavioral health care services are valid for the number of visits specified and will have a begin date and an end date. See Sections 6 and 7 of the TRICARE North Region Provider Handbook for prior authorization requirements.

Depending on the type of beneficiary requesting the service, TRICARE may require prior authorization for nonemergency inpatient and some outpatient services. Civilian network and non-network providers must obtain prior authorization for all services requiring prior authorization, as defined by Health Net and TRICARE.

Because these prior authorization requirements are subject to change, Health Net created the Prior Authorization, Referral and Benefit Tool, available at www.hnfs.com, for providers to use to determine current prior authorization requirements.

- Providers can enter a valid Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code into the tool to determine whether the service requires prior authorization.
- Providers without Internet access can call Health Net at 877-TRICARE (877-874-2273) for assistance.

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**Network Utilization**

TRICARE network or military treatment facility (MTF) providers should be the first option in TRICARE patient care. In most cases, patient care can be arranged swiftly through TRICARE’s vast provider network while meeting access-to-care standards, such as wait and drive time. TRICARE network and participating providers are expected to refer TRICARE Prime beneficiaries to TRICARE network providers whenever such providers are available. Requests for specialty care referrals or outpatient treatment authorizations that are to non-network providers will be redirected to MTF or TRICARE network providers.

**Requesting Referrals or Prior Authorizations from Health Net**

Civilian providers can request referrals or prior authorizations from Health Net online, by fax or by telephone. Civilian providers who have Internet access are encouraged to use the Online Authorization and Referral Submission Tool at www.hnfs.com, for electronic submission of prior authorization requests. Providers may also track the status of their request online via the Referral and Authorization Status Tool. Use of the Online Authorization and Referral Submission Tool reduces processing time and can increase your office productivity and efficiency.

**Faxing Requests**

If faxing a request, civilian providers must complete the TRICARE Service Request/Notification form. Access the form and view a completed sample form with detailed instructions at www.hnfs.com. To prevent processing delays, remember these important guidelines when completing and faxing the form:

- If filling out the form by hand, be sure to write legibly so that all letters and numbers are clear.
- Complete every section of the form, including clinical history, previous treatment and supporting test results in order for Health Net to process the request in a timely fashion.
- Once the form is complete, fax it to 888-299-4181 (outpatient) or 877-809-8667 (inpatient). Do not include a fax cover sheet.
- Fax each patient referral or prior authorization request separately.

**Guidelines for Prioritizing Referral Requests**

| When the care is required within 24 hours: | • Do not send a fax or submit the request online.  
• Call Health Net for a telephone referral request at 877-TRICARE (877-874-2273).  
• Choose the option for authorizations and referrals.  
• Clearly state that the referral is urgent when speaking with the Health Net representative. |
| --- | --- |
| When the care is required within 72 hours: | • Online—Submit the request using the Online Authorization and Referral Submission Tool at www.hnfs.com.  
• Fax a completed TRICARE Service Request/Notification form without a cover sheet to 888-299-4181 (outpatient) or 877-809-8667 (inpatient)  
• Write the word “URGENT” in large capital letters at the top to identify the need for expedited processing. |
| When requesting a routine referral or prior authorization¹: | • Make the request at least seven (7) days prior to the anticipated date of the service in one of the following ways:  
• Online—Submit the request using the Online Authorization and Referral Submission Tool at www.hnfs.com.  
• By fax—Fax a completed TRICARE Service Request/Notification form without a cover sheet to 888-299-4181 (outpatient) or 877-809-8667 (inpatient). |

¹Routine requests relate to care needed within the four-week TRICARE specialty care access standards. Nearly all requests are “routine” requests unless the patient needs care in less than 72 hours.

**Returning Consultation Reports to Referring Providers**

Specialty care providers are required to submit clearly legible specialty care consultation or referral reports, operative reports and discharge summaries to the referring provider within seven (7) business days of the initial appointment. In urgent and emergency situations, a preliminary report of a specialty consultation shall be submitted to the initiating provider within 24 hours or by the next business day.

**Guidelines for Submitting Reports**

| For MTF-Refereed Patients | Submit the clearly legible reports to the MTF’s secure local fax number identified on the referral/authorization letter provided by Health Net. Fax numbers are also available at www.hnfs.com. |
| For Civilian-Refereed Patients | Follow the normal process for coordinating reports with other civilian providers. |