



## Outpatient/Ambulatory Opiate and SUD Treatment Request Form

Please use self-service portal at **HumanaMilitary.com** for TRICARE referrals.  
If Internet access not available, fax forms to 1-877-378-2316.

Date submitted:

### Beneficiary information

Patient name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Patient ID or SSN:	Active Duty Service Member? <input type="checkbox"/> Y <input type="checkbox"/> N	
Address:	City/State/Zip:	
DoD benefit #:	Telephone #:	

### Referring provider

Provider name:	TIN/NPI:
MTF/eMSM:	TIN/NPI:
Address:	City/State/Zip:
Telephone #:	Fax #:

### Servicing provider

Provider type: ☐ M.D. ☐ D.O. ☐ Ph.D. ☐ CCSW ☐ CPNS

Provider name:	TIN/NPI:
Specialty:	Sub-specialty:
Telephone #:	

### Background information

Please list and describe current psychiatric and medical conditions:

Dx (DSM-5/ ICD-10)	Onset	Description (include symptoms and treatment)

Please list and describe current medication(s):

Medication	Psychotropic	Medical	Prescribing MD	PCM	Psychiatrist	Other
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe substance use history:

Substance type and method of ingestion	Amount	Frequency	Date of last use

Current participation in community-based support group? ☐ Y ☐ N If yes, frequency of attendance: x per/ ☐ wk. ☐ mo.  
Is there a sponsor? ☐ Y ☐ N

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### Service request information

Induction date:

Anticipated completion date:

Rx name:

Dosage/interval:

Quantity:

x per day

CPT code	Service (including modality)	Units

Please respond to the following (mark all that apply):

- ☐ Prior failed attempt(s) with a medication assisted treatment in the past 12 months.
- ☐ Non-compliant or **GAPS** in therapy since initial authorization. (If yes, attach explanation.)
- ☐ Pregnant or breastfeeding.

Signature indicates that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program.

Provider signature:

Date: