Humana Military | TRICARE

# 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: | ☐ M ☐ F | DOB: |
| Patient ID or SSN: | Active Duty Service Member? ☐ Y ☐ 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 |
|---|---|---|---|---|---|---|
| | ☐ | ☐ | | ☐ | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ | ☐ |

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 ☐ 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: