Residential Treatment Center (RTC) form

Initial review

Beneficiary information

Patient name: _____ ☐ Male ☐ Female

DOB: _____ (TRICARE RTC benefit is for under age 21 years, with a behavioral health primary diagnosis)

Patient ID or sponsor SSN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Planned target date of admission: _____

Referring/Ordering provider

Provider name: _____ License type: _____

TIN/NPI: _____ Phone #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Is the requesting provider a military hospital or clinic (MTF)? ☐ Yes ☐ No

Military hospital or clinic facility name: _____

Facility point of contact: _____ Facility phone #: _____

Facility order ID: _____ Facility referral ID: _____

Facility Address: _____

City: _____ State: _____ ZIP: _____

Proposed TRICARE-certified residential treatment facility

RTC facility name: _____ NPI/Tax ID: _____

Address: _____

City: _____ State: _____ ZIP: _____

If unknown, type "TBD" and nearest TRICARE-certified location will be suggested.

Note: Referring provider must submit this referral form online to HumanaMilitary.com or fax (877) 378-2316 as well as send to the proposed RTC program.

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Clinical information

DSM-5 diagnoses: _____

Medications (or attach list): _____

_____

Check one or more that applies:

☐ Beneficiary is believed to be an ongoing potential danger to self or others

☐ Beneficiary exhibits patterns of disruptive behavior, with evidence of disturbances in family functioning, social relationships and persistent psychological and or emotional disturbances

☐ Moderate to severe psychiatric or behavioral or other comorbid condition, with serious dysfunction in daily living or inability to function in age appropriate roles

Reason or precipitant to admission symptoms:

Previous treatment history:

Family therapy plan:

Biopsychosocial assessment(s):

Discharge planning and estimated length of treatment: _____

Additionally, the following are deemed true with this submission of referring provider:

- Recommended treatment is necessary, appropriate, and not feasible at lower level of care, or lower level of care efforts exhausted.
- Patient is believed to have sufficient ability to participate & respond to therapeutic modalities.
- The parent/guardian will actively participate in family therapy and continuing care of the patient unless therapeutically contraindicated.

Submit referral form online at HumanaMilitary.com or fax to (877) 378-2316

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