Outpatient Request Form

Health Net® FEDERAL SERVICES | TRICARE®

Submit requests online at www.hnfs.com for easy submission and quick status updates or fax to 1-888-299-4181.

Clinical Priority: Care must be rendered:

☐ **Routine – must be seen within 28 days**

☐ **Urgent – must be seen within 72 hours***

Clinical justification for Urgent priority must be attached or noted below. If not provided, request will be processed as Routine.

Service Type

☐ Specialty Referral/ Global Maternity

Q1

☐ Physical or Occupational Therapy

☐ OP Behavioral Health

Q2

☐ OP Medical Care/Procedure

☐ DME/Radiology

☐ Speech Therapy

Q3

☐ Outpatient Surgery

☐ IV Therapy/Home Health

☐ Adjunctive Dental

☐ Hospice/Respite Care

IP

Note: Inpatient services must be requested using the Inpatient TRICARE Service Request/Notification Form.

Requesting Provider Information

Requesting Provider **Telephone** Number: ( ) -

Requesting Provider **Fax** Number: ( ) -

Contact Name:

Requesting Provider/Facility Name:

Physician State License #:

Requesting Provider NPI #:

Billing Tax ID #: | Correspondence Preference: ☐ Fax ☐ US Mail

Is the requesting provider performing the service? ☐ Yes ☐ No

Essential Service Information

Is this a continuation/extension of services? ☐ Yes ☐ No

Date of Service: / / | Has this service been provided? ☐ Yes ☐ No

Is this behavioral health? ☐ Yes ☐ No | Is this a BH extension? ☐ Yes ☐ No

Is this an Initial 8? ☐ Yes ☐ No

Patient Information (Please complete all fields.)

Sponsor SSN/DOD Benefits Number:

Patient Name (Last, First, MI): Patient Date of Birth: / /

Patient Address: ZIP Code:

Street City State

Patient Home Phone: ( ) - Other Health Insurance:

Servicing Provider Information (Complete all applicable fields.)

Specialty:

Servicing Provider Name: Phone: ( ) -

Address: Fax: ( ) -

Facility Name (If Applicable): Phone: ( ) -

Address: Fax: ( ) -

Requested Service Information (Complete as many sections as required.)

Diagnosis: Code: Description:

Code: Description:

Service 1: CPT/HCPC/NDC Code: Description:

Number of Visits: Frequency: Duration:

If DME: ☐ Purchase ☐ Rental If global maternity – due date:

Service 2: CPT/HCPC/NDC Code: Description:

Number of Visits: Frequency: Duration:

If DME: ☐ Purchase ☐ Rental

Service 3: CPT/HCPC/NDC Code: Description:

Number of Visits: Frequency: Duration:

IF DME: ☐ Purchase ☐ Rental

Clinical Justification: