Case Management
Patient Referral Form

TriWest provides Case Management (CM) services for West Region TRICARE beneficiaries who:

- Have a complex medical, surgical or behavioral health condition
- Have high-risk psychosocial risk factors
- Receive medical care in the TRICARE civilian network.

To request Case Management services, please fax this completed form to the TriWest hub office responsible for the state in which the beneficiary resides. Please include any additional information that may assist the Case Manager in providing services to your beneficiary.

Hub	States Included	Fax Number
Northwest	Alaska; Northern Idaho; Oregon; Washington	1-866-269-5881
Southwest	Yuma, Arizona; California; Nevada	1-866-269-5828
Mountain	Arizona; Southern Idaho; Montana; New Mexico; El Paso, Texas; Utah	1-866-269-5819
Central	Colorado; Iowa; Kansas; Minnesota; Missouri; Nebraska; North Dakota; South Dakota; Wyoming;	1-866-312-5840
Hawaii	Hawaii	1-866-269-5814
Corporate	Transplant Referrals (region-wide)	1-866-269-5758

Please check **one** box below – the type of referral being made:

□ **Medical/Surgical** □ **Behavioral Health** □ **Transplant**

Patient Information (please print)

Last Name: ________________________ First Name: ________________________

Patient's Date of Birth: ______________ Sponsor's Social Security Number: ________________

Home Address: ____

Home Phone Number: (_____)______________ Cell/Other Number: (_____)______________

Referral Source Information (please print)

Name of Person Completing Form: ____________________Phone Number: (_____)__________

Patient's Primary Physician: ____

Phone Number: (_____)__________________ Fax Number: (_____)__________________

Specialist(s) Involved in Care:

Name(s): ____

Phone Number(s): (_____)________________ Fax Number(s): (_____)________________

1. Reason for Referral ____

2. Is the patient currently receiving any of the following?

□ None □ Inpatient Acute Care □ Home Health Care □ Chemotherapy

□ Infusion □ Inpatient Rehabilitation □ Outpatient Therapies □ Radiation Therapy

□ SNF □ Behavioral Health/Substance Treatment Other (please explain) ______________________

3. Has the beneficiary or primary caregiver been informed that a CM referral was being submitted? Yes _____ No _____

4. If Behavioral Health Referral, has the patient consented to Mental Health/Substance abuse services? Yes ____ No ____

Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations of this may be punishable by fines, imprisonment, or both.