



PO BOX 43350  
PHOENIX AZ 85080-3350

UM14CX

December 13, 2007 1

Tom Jones, MD 2  
101010 W. Overpass Drive 4  
Phoenix, AZ 85055

Sponsor SSN: xxx-xx-8765 3  
Beneficiary's DOB: 06/20/1963 5

**AUTHORIZATION APPROVAL  
CONSULT / TREATMENT REPORT REQUESTED**

RE Beneficiary: James Smith 6  
Reference Number: 0000058954 7  
MTF Order Number: 121212 8

Dear Tom Jones, MD 2

TriWest Healthcare Alliance has approved a request from Linda Jackson, MD 9 to have you provide the service(s) listed below for this patient between the dates of 12/13/07 10 – 1/12/08. 11

The services included in this approval are those that are frequently ordered during the course of treatment for similar episodes of care. This patient may not require all of these services. This authorization must be used in conjunction with a specific order.

<u>Procedure</u> 12	<u>Description</u> 13	<u>Quantity</u> 14	<u>Type</u> 15
Laminectomy	Spinal Surgery	1	Surgery

If clinical information was received from Linda Jackson, MD 9 it is included in this fax transmission.

James Smith 6 has been notified to contact your office to schedule an appointment. If one is not available by 1/12/08 11, this authorization will expire and another will have to be obtained by the patient. Please do not initiate contact with the beneficiary. The beneficiary may choose to select another network provider for this service.

Please send your consult / treatment or referral reports and other appropriate clinical information directly to Linda Jackson, MD 9 at FAX: (602)-555-5555 16 or 456 E. Greenway Rd., Phoenix, AZ 85201 17. Use the attached Consult / Treatment Report Fax Cover Sheet when returning reports.

Payment is subject to the beneficiary's TRICARE eligibility on the date of service and claim adjudication policies. To confirm the beneficiary's eligibility for this service(s), please log on to [www.triwest.com](http://www.triwest.com) or call 1-888-TRIWEST (874-9378). To utilize the self-service features, you will need your Provider Tax ID number, Sponsor SSN, and Patient Date of Birth.

If you have any questions about this letter, please call 1-888-TRIWEST (874-9378).

Sincerely,

TriWest Healthcare Alliance

The information contained in this facsimile transmission is protected pursuant to Federal law and is intended for use only by the party to which it is addressed. If you are not the intended recipient, you are hereby notified that any use, dissemination or copying of this communication is strictly prohibited. If you have received this facsimile in error, please notify us immediately at 866-240-0382 and destroy the information.

SAMPLE

# TRICARE Consult / Treatment Report Fax Cover Sheet

Fax To: (602)-555-5555 16

**TO:** Linda Jackson, MD 9  
456 E. Greenway Rd.,  
Phoenix, AZ 85201 17

**FROM:** Tom Jones, MD 2

**Reference Number:** 0000058954 7

**MTF Order Number:** 121212 8

**Re:** James Smith 6

**Beneficiary DOB:** 06/20/1963 5

**Your support is needed for Continuity of Care.**

Please use this page as a fax cover sheet when returning your consult / treatment or referral reports and other relevant clinical information to update the referring provider regarding your care of this beneficiary. Thank you.

SAMPLE

# Servicing Provider Authorization Approval Letter Definitions

In the preceding sample servicing provider authorization approval letter, there are numbers following each data field. A definition of what each number means is provided below:

- 1 **Date** – date the letter was sent.
- 2 **Servicing Name** – name of servicing provider.
- 3 **Sponsor SSN** – sponsor’s Social Security Number.
- 4 **Servicing Address** – physical address of servicing provider.
- 5 **Beneficiary’s DOB** – beneficiary’s date of birth.
- 6 **Beneficiary Name** – beneficiary’s name.
- 7 **Reference Number** – reference number for approved authorization.
- 8 **MTF Order Number** – number used by military treatment facility (MTF) to identify patients in the Composite Health Care System; part of contract requirement with government and has no impact on servicing providers.
- 9 **Requesting Name** – name of requesting provider.
- 10 **Referral or Authorization Begin Date** – beginning date for which approved services may be provided.
- 11 **Expiration Date** – date in which the referral or authorization expires.
- 12 **Procedure** – name of the approved procedure.
- 13 **Description** – description of the approved procedure.
- 14 **Quantity** – number of times or units for which the procedure is approved (e.g., office visits, allergy injections, etc.).
- 15 **Type** – description of approved services (e.g., office visits, allergy injections, MRI, etc.).
- 16 **Requesting Fax** – fax number of the requesting provider. If a civilian provider, it will be the civilian provider’s office fax number. If a MTF provider, it will be the TriWest consult tracking fax number.
- 17 **Requesting Address** – address of requesting provider. If a civilian provider, it will be the civilian provider’s office mailing address. If a MTF provider, it will be the TriWest Service Center for that MTF.

## TRICARE Consult Report Fax Cover Sheet

The last page of your referral/authorization approval letter serves as a cover sheet for you to fax your consult report to the referring provider. Just place the consult report after the fax cover sheet and fax to the pre-populated fax number on the cover sheet. Using this cover sheet will ensure the consult report gets to the correct location in a timely manner.