TRIWEST HEALTHCARE ALLIANCE®

Previous Authorization Number:

AK SECONDARY AUTHORIZATION REQUEST (SAR) FORM

SECTION I: PATIENT INFORMATION

Last Name:	First Name:	DOB:	SSN:
Address:	City:	State:	Zip:

SECTION II: REQUESTING PROVIDER INFORMATION

Requesting Provider:	Contact Person:
TIN:	Phone:
Address:	Fax:
Specialty (type):	Group Name:

SECTION III: TYPE OF CARE REQUEST

☐ Routine ☐ Urgent ☐ Emergent	Diagnosis: (ICD 10 Code/Description):

Date of Service and/or Anticipated Length of Care:

CPT/HCPCS Code/Description of requested service (include units/visits):

Is this a referral to another specialty? ☐ Yes ☐ No If yes, please fill out the servicing provider/specialty information below

Servicing Provider/Specialty:	Contact Person:
TIN:	Phone:
Address:	Fax:
Facility:	Contact Person:
TIN:	Phone:
Address:	Fax:

SECTION IV: TYPE OF SERVICES REQUESTED

☐ PT ☐ OT ☐ Speech Therapy Frequency& duration:	Surgical Procedure: ☐ Inpatient ☐ Outpatient (List facility name in Section III & Complete Discharge Needs (Section VI))
☐ In-Office Procedure	Inpatient Care: ☐ SNF ☐ Acute Rehab ☐ BH
☐ Additional Office Visits (list # needed):	☐ Emergency Room Care
☐ Labs: (If done outside of office, please provide a facility - above)	☐ Radiology / Imaging (Utilize the facility box if outside of office)

☐ Pre-Op Labs ☐ Chest XRAY ☐ EKG Other: ☐ Type & Screen ☐ Type & Cross

SECTION V: CLINICAL INFORMATION

To avoid delays in care, include appropriate documentation such as office notes, current treatment plans, clinical history, laboratory results, radiology results and or medications to support the medical necessity of services requested. Additional information attached?: ☐ Yes ☐ No

Admission or Discharge Information:

SECTION VI: DISCHARGE NEEDS

(Must be completed if requesting Inpatient Admission / Procedure)

☐ DME – Item Description & HCPCS Codes (to be provided by VAMC):

☐ Home Health or Home Infusion Care – list specific services, duration and/or frequency

☐ Skilled Nursing Facility	☐ Inpatient Acute Rehab

☐ Other Needs:

To facilitate timely review of this request, the most recent office notes and plan of care must accompany this form. The Anchorage VA Medical Center will review and make a determination within fourteen (14) business days and notify you of their decision. To submit request please fax to Anchorage VA Medical Center at 907-257-7418.