ValueOptions

TRICARE OUTPATIENT RETROSPECTIVE Review Form (Penalty Applies)

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PLEASE PRINT **FILL OUT *COMPLETELY* TO AVOID DELAYS**

THE FOLLOWING MUST ACCOMPANY THIS REQUEST:

Explanation of Benefits (EOB): showing denial of claims payment".

PATIENT INFORMATION

Patient's Name:_____ Sponsor #:_____ ID#:_____

DOB:_____ State:_____ Zip Code:_____ Phone#:_____

PROVIDER INFORMATION

Provider Name:_____ Phone#:_____

Fax #:_____State: _____Zip Code: _____

DSM-IV TR Diagnosis

Axis I - _ _ _._ _ / _ _ _._ _ / _ _ _._ _ Axis II - _ _ _._ _ / _ _ _._ _ Axis III - _____

TREATMENT REPORT

Clinical Information for DATE(S) Of SERVICE RETROSPECTIVE REVIEW IS BEING REQUESTED

_____

_____

_____

_____

REQUESTED RETRO AUTHORIZATION:

*CPT Code:*_____ *DATE(S) OF SERVICE:*_____

*CPT Code:*_____ *DATE(S) OF SERVICE:*_____

*CPT Code:*_____ *DATE(S) OF SERVICE*:_____

_____ _____

Provider's Signature Date

Disclaimer: ***Authorization indicates that ValueOptions has determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered.***