HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Inpatient Request Form

Fax to: 1-844-818-9289

Admission Type	☐ Emergency Admit* **Date of Admit:**	☐ Elective Admit **Anticipated Date of Admit:**

For emergency admissions, if face sheet is attached, please put sponsor's Social Security number here: _____-____-_____

Facility Type	☐ **Physical Health**	☐ Acute Care Hospital	☐ Acute Rehab Facility/Unit	☐ Long Term Acute Care (LTAC)	☐ Skilled Nursing Facility (SNF)
	☐ **Mental Health**	**Psychiatric Inpatient Admissions** ☐ Acute Psychiatric Emergency Admission ☐ Elective Admission to a Residential Treatment Center (for children and adolescents) ☐ Elective Psychiatric Admission for Eating Disorder	**Substance Use Disorder Inpatient Admissions** ☐ Detox (not medical admission) ☐ Substance Use Disorder Rehab	**Partial Hospitalization Program (PHP)** ☐ **Psychiatric (to include eating disorder PHP)** ☐ Full Day ☐ Part Day ☐ **Substance use disorder rehab** ☐ Full Day ☐ Part Day **Intensive Outpatient Program (IOP)** ☐ Psychiatric (to include Eating Disorder) ☐ Substance Use Disorder	**Services for Active Duty Service Members ONLY** ☐ Inpatient PTSD Active Duty Program

Patient Information

SPONSOR SSN/DoD Benefits Number:		**Patient** Date of Birth:	
Patient Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	ZIP:
Home Phone:			
Other Health Insurance ☐ Yes ☐ No	Policy #:	Carrier:	

Requesting Provider Information

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

Provider Name:		Contact Name:	
Phone:	Fax:	NPI #:	Tax ID #:

Servicing Provider Information

Provider Name:		Specialty:	
Phone:		Fax:	
Address:	City:	State:	ZIP:

Hospital/Health Care Facility Name (Required)

Name:			
Phone:		Fax:	
Address:	City:	State:	ZIP:

Requested Service: If additional codes are being requested, please attach additional sheets or use additional comments field below.

Diagnosis Code:	Description:		
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CPT Code:	Description:	Units (BH):	Frequency (BH): /week
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Please submit clinical information necessary to process this request. Additional comments: