Provider Fax Cover Sheet

To: TRICARE West Region **Fax:** _____

From: _____ **Fax:** _____

Number of pages (including cover sheet): _____

Patient Name: _____

Date(s) of Service: _____

TRICARE Claim Number: _____

Tax Identification Number: _____

Reason for Correspondence

__ Corrected Claim: Corrections to be made: _____

_____

__ Referral Information from PCM (claims processing with Point of Service Option)

__ Duplicate Review – Supporting medical documentation for services denied as a Duplicate

__ ClaimCheck Review – Supporting medical documentation for services denied per ClaimCheck

__ Other: _____

_____

Please use the appropriate secure FAX number from the list below:

Routine Correspondence: 844-869-2812

Medical Review Documents: 844-730-1371

Legal Correspondence: 844-730-1370

Third Party Liability Forms: 844-869-2813

Durable Medical Equipment: 844-730-1367

Other Health Insurance Updates: 844-730-1372

ECHO Correspondence: 844-730-1368

Provider Data Management: 844-730-1373

Revised: 10/02/2017