Letter of Referral (LOR)

Physician Referral Form for TRICARE beneficiaries accessing care with Licensed Mental Health Counselors, Licensed Professional Counselors, or Pastoral Counselors.

Instructions: Please submit this completed form with initial claim for TRICARE patient indicated or **Fax to (803) 462-3990**. Continued physician oversight must be indicated on all subsequent claims by listing referring physician name in box 17 or box 19 of your CMS-1500 claim form. For electronic claim submissions, please contact the EMC help desk at 1-800-325-5920 to verify the best way to indicate continued physician oversight for the electronic billing software method you use.

For Claims Payment Purposes Only - - Do Not Fax To ValueOptions.

Patient Name: ______________________________ DOB: ______________ Sponsor #: _________________

Patient Address: ____

City/State: ____ Phone: _______________________________

Reason for Referral/Disposition: ____

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ICD-9 Diagnosis: ____

Print Name of LMHC, LPC, or PC receiving this referral: ____

The referring physician is providing:

REFERRAL ONLY: ☐ REFERRAL AND OVERSIGHT/SUPERVISION: ☐

Please Note: TRICARE Policy Manual 6010.54M, Chapter 11, Section 3.1, states that in order for Mental Health Counselors (LMHCs and LPCs), and Pastoral Counselors (PCs) to be considered for benefits on a fee-for-service basis by TRICARE, the beneficiary/patient must be evaluated by a physician who provides a diagnosis and referral to the LMHC, LPC, or PC, prior to the start of treatment. A physician must also provide continued and ongoing oversight and supervision of treatment. Oversight and supervision documentation must be submitted with claims. Failure to follow this requirement may result in non-payment. Beneficiaries will be held harmless. It is the responsibility of the civilian provider (not the beneficiary) to ensure referral and oversight is obtained. Frequently military physicians elect not to provide the required referral and oversight, or may be willing to submit a referral but not provide ongoing oversight. ValueOptions may be able to assist with finding a civilian physician in these cases.

Referring Physician Information:

Print Name: _______________________________________ Is the Physician a PCM? _____ YES _____ NO

Practice Location: ____

City: ______________________________ State: __________________ Phone #: _______________________

Signature: ____ Date: __________________________

This form is provided as a resource for optional use.

04/2008