

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. If filing electronically, please call (800) 325-5920 for assistance. Continued physician oversight must be indicated on all subsequent claims.

Patient Name: _____ DOB: _____ Sponsor #: _____

Patient Address: _____ City/State: _____ Phone: _____

Reason for Referral/Disposition: _____

ICD-9/DSM-IV 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 6010.47M, Chapter 10, Section 2.1, 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.

Referring Physician Information:

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

Practice Location: _____

City: _____ State: _____ Phone #: _____

Signature: _____ Date: _____