TRICARE OVERSEAS PROGRAM
CLAIM DEVELOPMENT WORKSHEET

Instructions for Reimbursement of Medical Expenses:

This Claim Development Worksheet must be completed in full by the health care provider, signed by both the patient (beneficiary) and provider, and sent with an accompanying itemized invoice to the address indicated on your authorization in accordance with the timely filing requirements of the TRICARE Overseas Program (visit www.tricare-overseas.com/contactus for claims address information).

1. Patient Details:

Authorization Number:			
Name:	First	Initial	Last
Date of Birth:	(YYYYMMDD)		
Address:			
Gender:	Male ☐	Female ☐	
Sponsor SSN or DBN:			
Sponsor Name:	First	Initial	Last
Relationship to Sponsor:			

2. Patient Signature:	**Date: (YYYYMMDD)**
(Required by Non-Institutional Providers Only)	

SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES THE INFORMATION PROVIDED IN PART ONE IS CORRECT AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION NECESSARY FOR CLAIMS PROCESSING.

3. Diagnosis: Describe condition for which the patient received treatment, supplies or medication		
If you know the appropriate diagnosis code (ICD-9 or ICD-10) please enter it here:		
Otherwise please write a description of the patient's diagnosis here:		
4. Emergency Room / Emergency Care?	**Yes** ☐	**No** ☐
5. Patient Account Number: Enter Provider's patient account number or invoice number here. This will assist in reconciling claim payments to your provider records.		
6. Other Health Insurance:		
Does the Patient have other health insurance?*	**Yes** ☐	**No** ☐
Name of the other health insurance:		
If yes, please note that TRICARE is always the secondary health insurance. Please submit claims to the other health insurance before claiming from TRICARE.		
Name of the insured party: Other health insurance policy number: Other health insurance effective dates: Amount paid by other health insurance:		
7. Beneficiary Payments: If the Beneficiary has paid any amount toward the cost of the health care services rendered, please also indicate the total paid by the beneficiary.		
Amount paid by beneficiary (and currency):		
8. Provider Details:		
Name:		
Address:		

9. Provider Signature:	**Date: (YYYYMMDD)**

**If any Third Party Liability cases are in progress, this must be clearly indicated. Any Third Parties will pay primary to TRICARE.*