SECTION 7:
TRICARE Overseas Program Provider Forms

Sample: CMS 1500 Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

SAMPLE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd.for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample: CMS 1500 Claim Form (continued)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

SAMPLE

Sample: UB-04 Claim Form

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 4 TYPE OF BILL | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a b | 9 PATIENT ADDRESS a b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 CODE OCCURRENCE SPAN FROM THROUGH | 36 CODE OCCURRENCE SPAN FROM THROUGH | 37

38 | 39 CODE VALUE CODES AMOUNT | 40 CODE VALUE CODES AMOUNT | 41 CODE VALUE CODES AMOUNT (a b c d)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1–22							
23	PAGE ____ OF ____	CREATION DATE					

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A	Policy 1	111					57
B	Policy 2	222					OTHER
C							PRV ID

58 INSURED'S NAME | 59 P REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H | I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 | 76 ATTENDING NPI QUAL LAST FIRST

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB No. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE

Sample: UB-04 Claim Form (continued)

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SAMPLE

Sample: International SOS Authorization Form

TRICARE AUTHORIZATION FORM
FOR OUTPATIENT CARE
TRICARE PRIME BENEFICIARY

To:
<<Provider Name>>
<<Provider Address>>
<<Provider City>>
<<Provider Country>>
Tel: <<Provider Phone Number>>
Fax: <<Provider Fax>>

Authorization Number: <<0NTL 22221>>

Date: 14 April 2010

Pages: 1

SERVICE(S) REQUEST IN RESPECT OF:	**<<Beneficiary Name >> <<Beneficiary DOB>>**

This is to confirm the Authorization for the above patient at **<<Provider Name>>** for outpatient care. This Authorization is only valid between **<<April 14 2010>>** and **<<July 14 2010>>.**

Priority	<<Routine/ Urgent>>
Specialty	<<Specialty Required>>
Preliminary Diagnosis	**As per referral** <<Preliminary Diagnosis>>
Number of Visits	<<Number of allowed visits>>
Scope	<<Evaluate and Treat>>
Instructions:	<<Evaluate and Treat>>

SAMPLE

Inclusions:
Further to medical information received, International SOS authorizes all reasonable, customary and necessary medical expenses within the scope of the approved authorization.

Medical Reports:
Please send a written medical report and discharge summary to the below addressee after this patient's episode of care / procedure. Please follow any special arrangements you may have between you and the Military Treatment Facility (MTF).

<<International SOS>>, Fax: <<International SOS Fax Number>>
<<International SOS Address>>

Priority:
For urgent medical appointments please return a copy of medical results within 24 hours.
For routine appointments please return a copy of medical results within 10 calendar days.

Important:
An authorization is issued for requested services, procedures, or admissions that require medical necessity review prior to services being rendered. The terms of this Authorization are only applicable to the specific service provider indicated above and to this instance of service requested.

Billing Instructions:
If the Beneficiary has "other" healthcare coverage in addition to TRICARE, the "other" healthcare coverage is the Primary Insurer. All invoices must reach us within 12 calendar months from date of service to avoid denial of settlement. An itemized invoice accompanied with a duly completed Claim Form and a copy of this Authorization Form is to be sent to the following address. :

<<International SOS Claims Department>>
<<Claims Department Address>>

For full terms and conditions of this Authorization Form, please refer to www.tricare-overseas.com . Alternatively, you may contact our office for a copy of the terms and conditions.

Yours sincerely
<<TRICARE TEAM>>
TRICARE Department

Sample: EDI (Electronic Data Interchange) Agreement Form

Electronic Submission of TRICARE Claims Form

An organization that has several providers can execute a single Form on behalf of the group. Only one authorizing individual is needed to sign this Form for the Clinic / Group. However a complete list of all locations and providers for which you will be billing will need to be completed on submission of this form (these may be listed on Appendix 1 for Individual Providers and Appendix 2 for Institutional Providers if submitted together with the Mutual Co-operation Protocol).

Physician Clinic Name: ____

TRICARE Assigned Provider ID: ____

NPI Number of Provider (if applicable – US Territories only):____________________

Claim Type (select one or both): ☐ Institutional Provider (Hospital or Ambulatory Day Surgery)
☐ Individual Provider or Group Practice

Please submit a completed Appendix 1 for Individual Provider or Group Practice and / or Appendix 2 for Institutional Provider

Please indicate your EDI submission option:

☐ 1. Online claim submission at www.tricare-overseas.com

☐ 2. Electronic claim submission using a vendor supplied EDI software program
Name of Vendor (if applicable) ________________________

☐ 3. Electronic claim submission using PC-ACE software provided by WPS

☐ 4. Clearinghouse or Billing Service
Name of Billing Service / Clearinghouse (if applicable) ________________________

SAMPLE

1. In submitting electronic transactions using option 2, 3 or 4 above, the Healthcare Provider will follow the specifications required by the most current version named under the HIPAA Transactions and Code Sets rules.

2. For claim transactions, the Healthcare Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered to be signed by the Healthcare Provider or the Healthcare Provider's authorized representative.

3. For claim transactions, the Healthcare Provider agrees to maintain a patient signature file. The Healthcare Provider understands INTL.SOS may validate through file audits those claims submitted via electronic media which are included in any quality control or sampling method requested by INTL.SOS. The Healthcare Provider understands that if no signed authorization is on file, an authorization must be obtained by the Healthcare Provider from the patient prior to electronic submission to INTL.SOS.

4. The Healthcare Provider acknowledges that INTL.SOS shall have no obligation with respect to the content of the information in claims to verify, check or otherwise inspect the information supplied by the Healthcare Provider. The Healthcare Provider further acknowledges that INTL.SOS is solely responsible for determining the completeness, accuracy and validity of the information and claims and that source documents for claims data are the responsibility of the Healthcare Provider.

5. INTL.SOS may apply edits as defined in the X12 ASC Implementation Guide or the WPS-TRICARE Companion Guide against any transaction. The Healthcare Provider understands that INTL.SOS will accept all valid transactions which meet such edit requirements and return errant transactions for correction.

Sample: EFT (Electronic Funds Transfer) Form for Providers

Electronic Funds Transfer (EFT) Claim Payment Request

If you are expecting to receive all your payments directly, please complete your bank details.
If you are processing all of your invoices through a billing agency or a corporate entity, please send them form to provide us with their bank details and a list of providers billing through them.

PROVIDER INFORMATION:

Do you use a billing agency? Yes / No (If Yes, please request your Billing Agency to complete the ***EFT Form for Billing Agency***)

TRICARE ID Number ______________ Provider Name ______________

City ______________ State ______________

Country ______________ Zip / Postal Code ______________

BANK DETAILS:

Please provide details of the Account Holder – including Account Holder's Street Address

Account Holder Name ______________ Tel Number ______________

Street Address ______________

Country ______________ Zip / Postal Code ______________

Bank Name ______________

Bank ID Code (Swift, FED, ABA, etc.) ______________ Full Bank Account Number (IBAN) ______________

Bank Street Address ______________ Bank City ______________

Bank State/ Country ______________ Bank Zip / Postal Code ______________

INTERMEDIARY BANK DETAILS:

Please provide details of the Account Holder – including Account Holder's Street Address

Intermediary Bank Name ______________ Tel Number ______________

Street Address ______________ City ______________

State / Country ______________ Zip / Postal Code ______________

Bank Swift Code ______________

SAMPLE

PAYMENT INFORMATION: Wire______________ (specify currency)

Authorization (Signature and Date Required)

______________ (Bank Accountholder) hereby authorizes International SOS and/or its dedicated Agents to make payments of any benefits payable to us by crediting the payments to my account at the bank or financial institution named above. I agree to notify in writing of any change relating to the information provided on this form or of a withdrawal of this authorization.

I agree that if, for any reason unearned payments are deposited into my account, I will immediately repay the full amount of any such payments. I further agree that if I do not immediately repay such unearned payments, I will be liable for all costs of collection. These costs include reasonable attorney's fees, incurred by International SOS and/or its dedicated Agents in the collection of such payments.

In the case of any overpayment of benefits to my account, I agree that International SOS may debit my account for such overpayment, without further authorization from me.

All bank charges incurred by our organization are our responsibility.

Signature Title Date

Organization Name

Please email this form back to:

Europe, Middle East & Africa	providerseurasiaafrica@internationalsos.com
Asia Pacific	providersasiapacific@internationalsos.com
Latin America and Canada	providerslatinamerica@internationalsos.com
Puerto Rico	provider.inquiries.PR@internationalsos.com

Sample: EFT Form for Providers Who Use a Billing Agency

Billing Agency - Electronic Funds Transfer (EFT) Claim Payment Request

If you use the services of a billing agency to submit claims on your behalf for TOP beneficiary claims, please request that your billing agency completes and returns this form along with your Mutual Cooperation Protocol.

BILLING AGENCY INFORMATION:

TRICARE ID Number ____________________ Billing Agency Name ____________________

City ____________________ State ____________________

Country ____________________ Zip / Postal Code ____________________

BANK DETAILS:

Please provide details of the Account Holder – including Account Holder's Street Address

Account Holder Name ____________________ Tel Number ____________________

Street Address ____

Country ____________________ Zip / Postal Code ____________________

Bank Name ____

Bank ID Code (Swift, FED, ABA, etc.) ____________________ Full Bank Account Number (IBAN) ____________________

Bank Street Address ____________________ Bank City ____________________

Bank State/ Country ____________________ Bank Zip / Postal Code ____________________

INTERMEDIARY BANK DETAILS:

Please provide details of the Account Holder – including Account Holder's Street Address

Intermediary Bank Name ____________________ Tel Number ____________________

Street Address ____________________ City ____________________

State / Country ____________________ Zip / Postal Code ____________________

Bank Swift Code ____

SAMPLE

PAYMENT INFORMATION: Wire______________________ (specify currency)

Authorization (Signature and Date Required)

________________________ (Bank Accountholder) hereby authorizes International SOS and/or its dedicated Agents to make payments of any benefits payable to us by crediting the payments to my account at the bank or financial institution named above. I agree to notify in writing of any change relating to the information provided on this form or of a withdrawal of this authorization.

I agree that if, for any reason unearned payments are deposited into my account, I will immediately repay the full amount of any such payments. I further agree that if I do not immediately repay such unearned payments, I will be liable for all costs of collection. These costs include reasonable attorney's fees, incurred by International SOS and/or its dedicated Agents in the collection of such payments.

In the case of any overpayment of benefits to my account, I agree that International SOS may debit my account for such overpayment, without further authorization from me.

All bank charges incurred by our organization are our responsibility.

Signature Title Date

Organization Name

Please email this form back to:

Europe, Middle East & Africa	providerseurasiaafrica@internationalsos.com
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