Appendix 1: Claim Form DD 2642

DD 2642: Updated April 2007

- PATIENT'S COPY -

1. PATIENT'S NAME *(Last, First, Middle Initial)*	2. PATIENT'S TELEPHONE NUMBER *(Include Area Code)* DAYTIME ( ) EVENING ( )
3. PATIENT'S ADDRESS *(Street, Apt. No., City, State, and ZIP Code)*	4. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)* ☐ SELF ☐ STEPCHILD ☐ SPOUSE ☐ FORMER SPOUSE ☐ NATURAL OR ADOPTED CHILD ☐ OTHER *(Specify)*
5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)* 6. PATIENT'S SEX *(X one)* ☐ MALE ☐ FEMALE	7. IS PATIENT'S CONDITION *(X both if applicable)* ACCIDENT RELATED? ☐ YES ☐ NO WORK RELATED? ☐ YES ☐ NO
8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.	8b. WAS PATIENT'S CARE *(X one)* ☐ INPATIENT? ☐ PHARMACY? ☐ OUTPATIENT? ☐ DAY SURGERY?
9. SPONSOR'S OR FORMER SPOUSE'S NAME *(Last, First, Middle Initial)*	10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER

11. OTHER HEALTH INSURANCE COVERAGE

a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. ☐ YES ☐ NO

b. TYPE OF COVERAGE *(Check all that apply)*
☐ (1) EMPLOYMENT *(Group)* ☐ (3) MEDICARE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE ☐ (7) OTHER *(Specify)*
☐ (2) PRIVATE *(Non-Group)* ☐ (4) STUDENT PLAN ☐ (6) PRESCRIPTION DISCOUNT PLAN

	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE *(Street, City, State, and ZIP Code)*	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE *(YYYYMMDD)*	f. DRUG COVERAGE?
INSURANCE 1				☐ YES ☐ NO
INSURANCE 2				☐ YES ☐ NO

REMINDER: Attach your other health insurances's Explanation of Benefits or pharmacy receipt that indicates the actual drug cost, amount the OHI paid, and the amount that you paid.

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.			13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?
a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT	☐ YES ☐ NO

HOW TO FILL OUT THE TRICARE/CHAMPUS FORM

You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.
3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.
5. Enter patient's date of birth (YYYYMMDD).
6. Check the box for either male or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." The form may be obtained from the claims processor, BCAC, or TRICARE Management Activity.
8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.
8b. Check the box to indicate where the care was given.
9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."
10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN).
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.
NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. *The claims processor cannot process claims until you provide the other health insurance information.*
12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim.
Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.
13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment available only in some local currencies.

DD FORM 2642 (BACK), APR 2007 Reset COPY 1 - PATIENT'S COPY

Aurora, CO 80011

Phone: (303) 676-3824

Fax: (303) 676-3981

Module Objectives

- **Explain who may file claims and to whom they should be submitted**
- **Explain the process involved in beginning to resolve a claim issue**
- **Explain three reasons why a claim may be denied**
- **Recognize what can and cannot be appealed**

24.6 Potential outcome of cases referred to TRICARE

- Criminal conviction
- Civil settlement
- Administrative action by contractor
- Termination action
- Exclusion action—removal from the TRICARE program

17.7 Where to send potential fraud cases:

TRICARE Region North
Health Net Federal Services
(800) 977-6761

TRICARE Region South
Humana Military Healthcare Services
(800) 333-1620

TRICARE Region West
TriWest Healthcare Alliance
(888) 584-9378

TRICARE Overseas
Wisconsin Physicians Service
(888) 777-8343

Express Scripts, Inc.
(800) 332-5455, ext. 67079

United Concordia
(877) 968-7455

TRICARE Management Activity
Program Integrity Office
16401 East Centretech Parkway

24.3 Who Commits Fraud?

The majority of fraud is committed by dishonest physicians and other health care professionals.

- Examples: Physicians, dentists, labs, hospitals, psychiatrists, ambulance companies, and clinics
- A lesser percent is attributed to patient fraud and abuse
- Fraud is also committed by contractors and employees

24.4 Common TRICARE Referral-Related Fraud/Abuse

- Billing for services and/or supplies not rendered
- Billing for excessive services in a 24 hour period
- Misrepresentation of services provided, provider of care, or beneficiary
- Billing for higher level of service than actually rendered
- Billing for unnecessary services or supplies

24.5 Fraud Indicators

- Excessive charges by provider
- Claims with excessive or vague documentation
- Correspondence for rapid adjudication
- Reluctance of provider to submit records
- Diagnosis or treatment inconsistent with patient's age or sex
- Provider who uses post office boxes for the remit to address
- Claims with misused or misspelled medical terms
- Erasures, cross-outs, or white out
- Providers routinely billing the same procedures to each patient regardless of diagnosis
- Claims handwritten in the same ink form for both beneficiary and provider portion of claim
- Provider is not in the same geographic area as the beneficiary, particularly when patterns occur
- Excessive billing by provider for low cost items or services
- High volume of treatment for a particular condition or diagnosis
- Overlapping services on the same date
- Too many providers for same date of service
- Conflicting dates of service
- Illogical places of service

- If the sanctions are appealed, an independent hearing officer will conduct a hearing administered by the TMA Appeals, Hearings, and Claims Collection Division in Aurora, Colorado.

24.0 Program Integrity

- The TRICARE Management Activity Office of Program Integrity:
  - Is the investigative arm of TRICARE
  - Provides management of the TMA anti-fraud program
  - Is responsible for national coordination and control of cases through their work with contractors, the Department of Justice, and investigative agencies
  - Provides oversight to all contractor program integrity units to ensure compliance in the area of anti-fraud activities
- Program Integrity is responsible for deterring fraud, waste, and abuse through:
  - Prevention
  - Detection
  - Coordination
  - Enforcement

24.1 What is Fraud?

Fraud is any intentional deception or misrepresentation that an individual or entity does which could result in an unauthorized TRICARE benefit or payment.

- TRICARE considers the following fraudulent acts under the program:
- Submitting claims for services not rendered or used
- Falsified claims or medical records
- Misrepresentation of dates, frequency, duration, or description of services rendered
- Billing for services at a higher level than provided or necessary
- Over-utilization of services
- Breach of provider participation agreement

24.2 What is Abuse?

Abuse is any practice by providers, physicians, or suppliers that is inconsistent with accepted medical or business practice.

- TRICARE considers the following abusive acts under the program:
  - Failure to maintain adequate medical or financial records
  - A pattern of claims for services not medically necessary
  - Refusal to furnish or allow access to records
  - Billing in excess of what is customary or reasonable
  - Pattern of waiving cost share or deductible

TRICARE For Life

Department	Address	Phone	Web site
Claims Submission	**WPS TRICARE For Life** PO Box 7890 Madison, WI 53707-7890	(866) 773-0404 TDD (866) 773-0405	www.tricare4u.com
Appeals	**WPS TRICARE For Life** Attn: Appeals PO Box 7490 Madison, WI 53707-7490	(866) 773-0404 TDD (866) 773-0405	www.tricare4u.com

Pharmacy

Department	Address	Phone	Web site
TMOP	**Express Scripts** P.O. Box 66518, St. Louis, MO 63166-6518	(866) 363-8667	www.express-scripts.com
Retail	**Express Scripts** P.O. Box 66518, St. Louis, MO 63166-6518	(866) 363-8779	www.express-scripts.com

23.0 Provider Sanction Determinations

- Provider sanction determinations occur when providers are expelled from TRICARE.
- Providers may be sanctioned by TRICARE because of the following:
  - Failure to maintain credentials
  - Provider fraud
  - Abuse
  - Conflict of interest or other reasons
- Only the provider or his or her representative can appeal.

TRICARE Europe

Location	Name	Address	City	State	ZIP	Telephone
Europe, Africa, Middle East	**WPS**	PO BOX 8976	Madison	WI	53708-8976	(608) 224-2727

TRICARE Pacific

Location	Name	Address	City	State	ZIP	Telephone
Western Pacific (Japan, Guam, Korea, Thailand, etc.)	**WPS**	PO BOX 7985	Madison	WI	53707-7985	(608) 301-2310

TRICARE Latin America, Canada, Puerto Rico & Virgin Islands

Location	Name	Address	City	State	ZIP	Telephone
All of Latin America, Canada, Bermuda, Virgin Islands	**WPS**	PO BOX 7985	Madison	WI	53707-7985	(608)301-2311
Puerto Rico	**WPS**	PO BOX 7985	Madison	WI	53707-7985	(800) 700-7104

West Region

Location	Name	Address	City	State	ZIP	Telephone
Alaska Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri (except St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	**WPS**	PO BOX 77028	Madison	WI	53707-7028	888-915-4001

South Region

Location	Name	Address	City	State	ZIP	Telephone
Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina Tennessee (excluding the Ft. Campbell area), Texas (except William Beaumont catchment area in El Paso and Cannon AFB, NM service are ZIP codes that fall in Texas)	**PGBA**	PO BOX 7031	Camden	SC	29020-7031	800-403-3950

Wisconsin

22.0 Claims Processors

North Region

Location	Name	Address	City	State	ZIP	Telephone
Connecticut, Delaware, District of Columbia, Florida Georgia Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina Tennessee (only those counties in Tennessee surrounding Ft. Campbell), Vermont, Virginia, West Virginia,	**PGBA**	PO BOX 870140	Surfside Beach	SC	29587-9740	877-874-2273

(Insert branch of Service) Point of Contact
Military Medical Support Office (MMSO)
P.O. Box 886999
Great Lakes, IL 60088-6999

- United States Public Health Service (USPHS) and National Oceanic and Atmospheric Administration (NOAA) members may contact their Beneficiary Medical Program SPOC at 1-800-368-2777 option 2.
- Coast Guard members may call 1-800-9HBA-HBA (1-800-942-2422).

21.0 Where to Get Additional Information for Your Beneficiaries

If you cannot answer beneficiaries' questions about their denials, direct them to the following:

- Regional TRICARE contractor or claims processor
- If you are from a Reserve component unit, contact the nearest military treatment facility, or a BCAC at the TRICARE Regional Office or TRICARE Area Office
- The local TSC
- Or write to:

TMA Appeals, Hearings, and Claims Collection Division,

16401 E. Centretech Parkway,

Aurora, Colorado

80011-9066

21.1 Beneficiaries must:

- Meet all the required deadlines
- Send appeals in writing with signatures
- Include copies of all supporting documents in their appeal. If they do not have the paperwork available, they should send their letter within the deadline and note that more information will be sent
- Keep copies of everything

19.0 Requesting a Formal Hearing

After all other steps have been taken; a beneficiary wanting a formal hearing. If so, he/she must send his or her request to:

TRICARE Management Activity

Appeals, Hearings and Claims Collection Division

16401 E. Centretech Parkway

Aurora, Colorado 80011-9066.

19.1 The request must be:

- Postmarked within 60 days of the decision being appealed
- Include a copy of the decision being appealed and any supporting documents not previously submitted
- If the beneficiary does not have all of the supporting documents, the request should state that the intention to submit additional information
- Encourage the beneficiary to keep copies of anything sent

An independent hearing officer will conduct the hearing at a location convenient to both the requesting party and the Government. The hearing officer will issue a recommended decision, and the TMA director (or designee) or the Assistant Secretary of Defense for Health Affairs will issue the final decision.

20.0 TRICARE Prime Remote Appeals

- In the event a request for specialty care is not approved, the active duty service member (ADSM) will be informed of the decision.
    - The ADSM may appeal this decision by first contacting the Military Medical Support Office (MMMSO) Service Point of Contact (SPOC).
    - ADSMs, their primary care manager, or other provider (if they do not have a primary care manager) may send additional written information or documentation to support the ADSM's request for specialty care to the SPOC.
- If the request is denied on appeal, the ADSM may appeal one more time to the Surgeon General or senior medical officer of his or her respective Service. The address for this second appeal will be provided to the ADSM following a denial of the first appeal.
- ADSMs from the Army, Navy, Air Force, and Marine Corps may contact their SPOC at 1-888-MHS-MMSO (1-888-647-6676). Send written inquires to:

18.0 What Cannot Be Appealed?

The following are examples of what cannot be appealed:

- The amount that the TRICARE contractor determines to be the allowable charge for a particular medical service.
    - The beneficiary may ask the TRICARE contractor for an allowable charge review, but cannot file an appeal.
- The decision by TRICARE, or its contractors, to ask the beneficiary for more information before action is taken on the beneficiary's claim or appeal request.
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers:
    - Although a beneficiary may want to receive care, or already has received care from a particular provider, the beneficiary cannot appeal a decision that denies the provider authorization to be a TRICARE provider, or a decision that suspends, excludes, or terminates the provider.
    - The provider in question may appeal in his or her own behalf.
- Decisions relating to eligibility as a TRICARE beneficiary:
    - Eligibility is determined by the branch of service and reported by DEERS.
    - Beneficiaries must appeal decisions regarding their eligibility through their branch of Service.

16.0 Who is Able to Appeal?

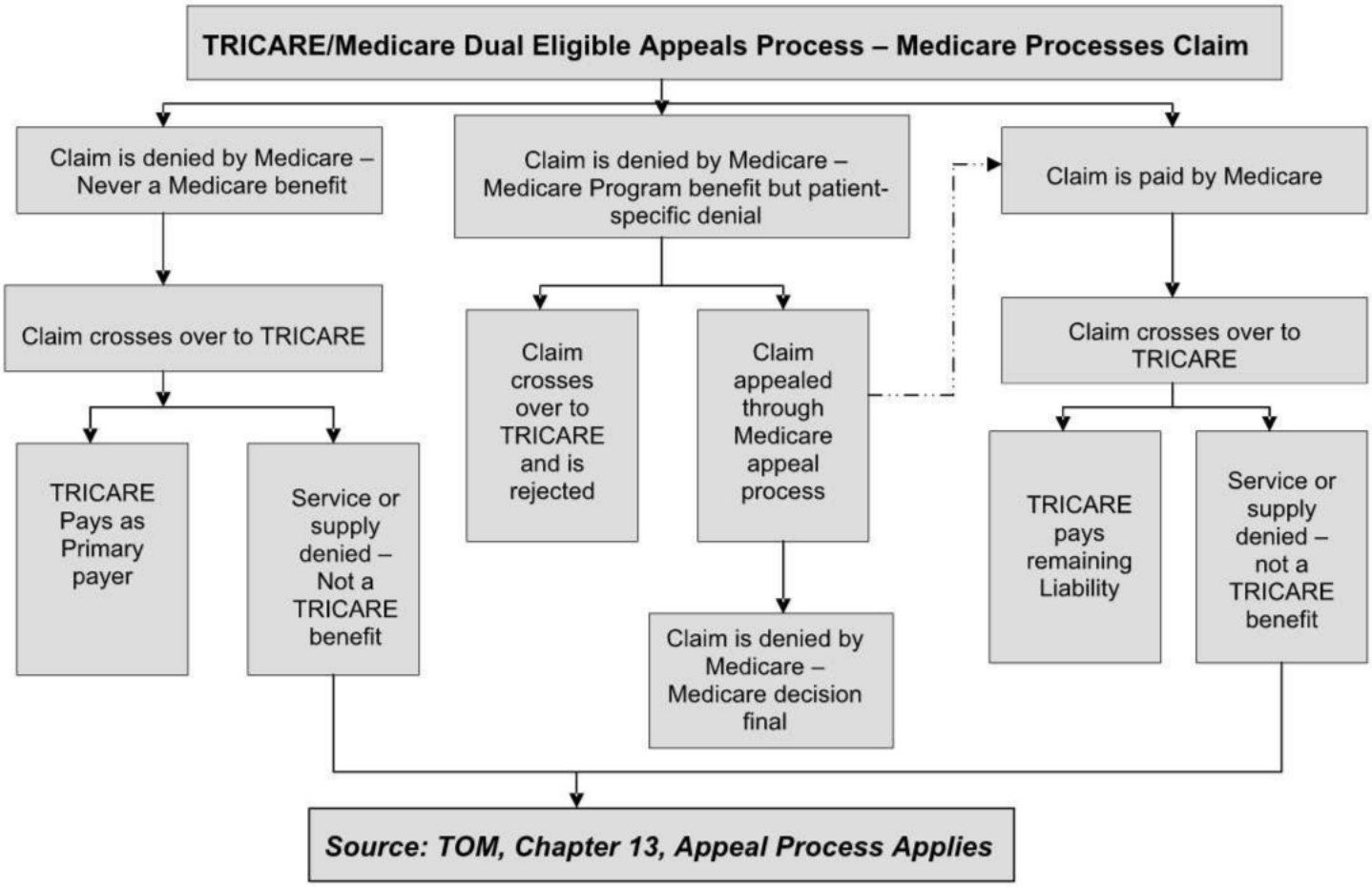
- Any TRICARE beneficiary, or a parent or guardian of a beneficiary who is under 18 years of age
- The guardian of a beneficiary who is not competent to act in his or her own behalf
- A health care provider who has been
    - Denied approval
    - Suspended, excluded, or terminated as a TRICARE-authorized provider
    - Providers who participate in TRICARE accept the TRICARE-allowable charge as their full fee
    - A representative appointed in writing by a beneficiary or provider
    - Providers who do not participate in TRICARE and network providers cannot file appeals
    - Certain individuals may not serve as beneficiary representatives due to a conflict of interest:
        - An officer (member of a uniformed services legal office)
        - HBA
        - Employee of the United States (employee of a uniformed services legal office or an HBA/BCAC)
    - **Exception**: That person is representing an immediate family member.
- The appealing party must be able to prove he or she is eligible for TRICARE benefits.

17.0 What Can Be Appealed?

- The facts of the beneficiary's case
    - Diagnosis
    - Necessity to be an inpatient
    - Denial of preauthorization for services, including mental health
    - Termination of treatments or services that have been previously authorized
    - Denial of TRICARE payment for services or supplies received
    - Termination of TRICARE payment for continuation of services or supplies that were previously authorized
    - Denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE

15.0 Appeals for Dual Eligibility Determinations

- Dual-eligible refers to beneficiaries who are eligible for both TRICARE and Medicare.
- When Medicare and TRICARE have both denied a claim and the beneficiary has successfully appealed the Medicare claim (Medicare has paid the claim), the beneficiary can appeal the TRICARE denial through the factual claim process above.



14.0 Appeals of Factual Determinations

- Factual determinations involve issues other than medical necessity, such as determining whether the service is covered under TRICARE policy or regulation.
- They also include foreign claims and denial of a provider's request for approval as a TRICARE authorized provider.

14.1 Appeals Process

- To file this type of appeal the beneficiary should do the same as they would for submitting a non-expedited medical necessity appeal.
    - If they are appealing an amount less than $50, the TRICARE regional contractor's decision is final.
    - If they are appealing an amount more than $50 and the letter identifies the TMA as the next level of appeal, they can request a formal review.
- To request a formal review, they must send a letter to the TMA within 60 days (postmarked or received) of the date on the initial determination or reconsideration decision and include copies of the decision along with additional supporting documents. TMA will issue a formal review decision.
- If the disputed amount is less than $300, the TMA's decision is final. If the disputed amount is more than $300, they can request an independent hearing.
- To request an independent hearing, they should send a hearing request to the TMA-Aurora within 60 days (postmarked or received) of the date of the decision being appealed and include a copy of the formal review decision being appealed and any supporting documents not previously submitted.
- An independent hearing officer will conduct the hearing at a location convenient to both the requesting party and the government. The hearing officer will issue a recommended decision and the TMA director (or designee) or the Assistant Secretary of Defense for Health Affairs will issue the final decision.
- Appeals and appeal correspondence for the TMA should be addressed to:

TRICARE Management Activity

Appeals, Hearings and Claims Collection Division

16401 E. Centretech Parkway

Aurora, CO 80011-9066

- The regional contractor reviews the case and issues a reconsideration decision and if the beneficiary disagrees with the reconsideration decision, they can appeal to the national quality monitoring contractor.

13.2 Expedited Appeal

- An expedited appeal should only be submitted to reconsider approval of inpatient stays or prior authorization of services.
- The denial decision the beneficiary receives will explain how to file an expedited appeal.

13.3 Both Expedited and non-Expedited

- The regional contractor will review the case and issue a second-level review decision:
    - If the beneficiary disagrees with this decision, the next level of appeal is through the national quality monitoring contractor.
- Send a letter to the national quality monitoring contractor:
    - The letter must be postmarked or received within 90 days of the date on the reconsideration decision.
    - A copy of the reconsideration decision and any supporting documents not previously submitted must be included in the letter.
    - If the beneficiary does not have all of the supporting documents, it should state in the letter that the beneficiary intends to submit additional information.
    - The beneficiary should keep copies of all paperwork.
    - The national quality monitoring contractor will review the case and issue a second reconsideration decision.
- The national quality monitoring contractor will review the case and issue a second reconsideration decision.
- If the amount is less than $300, the national quality monitoring contractor's decision is final.
- Appeals correspondence should be addressed to TMA.
- If the amount in dispute is less than $300, the reconsideration decision by the national quality monitoring contractor is final:
    - If the beneficiary disagrees, and the disputed services are $300 or more, the beneficiary can request TMA to schedule an independent hearing.
    - The address for TMA is:

TRICARE Management Activity
Appeals, Hearings, and Claims Collection Division
16401 E. Centretech Parkway
Aurora, Colorado 80011-9066

12.0 Appeals

12.1 Appeals Process

To appeal means to ask the TRICARE contractor or TRICARE Management Activity (TMA) for a review of the decision to deny a beneficiary's claim. The appeals process varies, depending on whether the denial of benefits involves:

- Medical necessity
- Factual
- Dual-eligible (beneficiaries eligible for both TRICARE and Medicare)
- Provider Sanction

All initial denials and appeal denials explain how, where, and by when to file the next level of appeal.

13.0 Appeals of Medical Necessity Determinations

- "Medical Necessity" is based on whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition.
- It may be necessary to show medical necessity for inpatient, outpatient, and specialty care.
- There are two kinds of medical necessity determination appeals: Non-expedited and Expedited.
    - Each has a different process.
    - Most appeals are Non-expedited.

13.1 Non-expedited

To file this type of appeal, the beneficiary sends a letter to the regional contractor at the address specified in the notice of the beneficiary's right to appeal, included on their EOB or other notification:

- The letter must be postmarked or received within 90 days of the date on the EOB or other decision.
- It should include a copy of the EOB or other decision, and all documents that support the position.
- If beneficiaries can't get all of the supporting documents in on time, they should send the appeal anyway and state in the letter their intention to submit additional information in the near future.
- The beneficiary should keep copies of all paperwork related to the appeal.

PGBA, LLC
TRICARE NORTH REGION
PO BOX 870140
Surfside Beach, SC 29587

HealthNet Federal Services

TRICARE EXPLANATION OF BENEFITS

This is a statement of the action taken on your TRICARE Claim.
Keep this notice for your records.

Date of Notice:	November 10, 2006
Sponsor SSN:	###-##-1035
Sponsor Name:	JACK DOE
Beneficiary Name:	JOHN DOE

JOHN DOE
123 25th ST
WASHINGTON, DC 20123

Benefits were payable to:
Whats-Up DERMATOLOGY CLINIC
PO BOX 1234
WASHINGTON, DC 20113

Claim Number:123456789-00-00

Services Provided By Date of Services		Services Provided		Amount Billed	TRICARE Approved	See Remarks
Whats-Up DERMATOLOGY CLINIC						
10/22/2006	001	Office visit	(99284)	$ 264.00	$ 84.09	1,2
Totals:				**$ 264.00**	**$ 84.09**	

Claim Summary

Amount billed:	264.00
TRICARE Approved:	84.09
Non-Covered:	179.91
Paid by Beneficiary:	0.00
Other Insurance:	0.00
Paid to Provider:	0.00
Paid to Beneficiary:	0.00
Check Number:	

Beneficiary Liability Summary

Deductible	84.09
Co-payment:	0.00
Cost Share	0.00

Benefit Period Summary

Fiscal Year Beginning:
October 01, 2006

	Individual	Family
Deductible:	84.09	84.09
Catastrophic Cap:	84.09	84.09

Enrollment Year Beginning:
October 01, 2006

Remarks

1 – CHARGES ARE MORE THAN ALLOWABLE AMOUNT
2 - $84.09 HAS BEEN APPLIED TOWARD THE FISCAL YEAR CATASTROPHIC CAP OF $1,000.00

PGBA, LLC
TRICARE SOUTH REGION
PO BOX 7032
CAMDEN, SC, 29020-7032

HUMANA Military Healthcare Services

TRICARE EXPLANATION OF BENEFITS

This is a statement of the action taken on your TRICARE Claim.
Keep this notice for your records.

Date of Notice:	October 24, 2006
Sponsor SSN:	###-##-7845
Sponsor Name:	JANE SMITH
Beneficiary Name:	JANE SMITH

JANE SMITH
123 S CHRISTMAS LANE
AROUNDTHEBEND, SC 203156

Benefits were payable to:
TRY CARE SOUTH
PO BOX 567
OVERTHEHILL, SC 203156

Claim Number: 345678901-00-00

Services Provided By Date of Services		Services Provided		Amount Billed	TRICARE Approved	See Remarks
TRY CARE SOUTH						
10/9/2006	1	Office/outpatient visit, est	(99214)	$ 95.00	$ 60.00	1,2,3
Totals:				**$ 95.00**	**$ 60.00**	

Claim Summary		Beneficiary Liability Summary	
Amount billed:	95.00	Deductible	0.00
TRICARE Approved:	60.00	Co-payment:	12.00
Non-Covered:	35.00	Cost Share	0.00
Paid by Beneficiary:	0.00		
Other Insurance:	0.00		
Paid to Provider:	48.00		
Paid to Beneficiary:	0.00		
Check Number:			

Benefit Period Summary

Fiscal Year Beginning:
October 01, 2006

	Individual	Family
Deductible:	12.00	0.00
Catastrophic Cap:	12.00	0.00

Enrollment Year Beginning:
October 01, 2006

Remarks

1 – CHARGES ARE MORE THAN ALLOWABLE AMOUNT
2- AMOUNT ALLOWED IS BASED ON DISCOUNT AGREEMENT
3- $12.00 HAS BEEN APPLIED TOWARD THE FISCAL YEAR CATASTROPHIC CAP OF $3,000.00

TRICARE Standard or Extra beneficiaries' annual deductibles and maximum out-of-pocket expenses by fiscal year. If a TRICARE Prime beneficiary, they calculate your maximum out-of-pocket expense by enrollment and fiscal year. (**Note**: The enrollment year beginning will appear on your EOB only if you are enrolled in TRICARE Prime.)

Remarks: Explanations of the codes or numbers listed in "See Remarks" appear here.

Toll-Free Telephone Number: The toll-free number for the claims processor for questions are on the TEOB.

11.0 Learning to Read an Explanation of Benefits (EOB)

PGBA or WPS: PGBA or WPS processes all TRICARE health care claims, depending on the region where you live.

Prime Contractor: The name and logo of the regional contractor that is responsible for the claim.

Date of Notice: The date the claims processor prepared the TRICARE EOB.

Mail to Name and Address: The address the TRICARE EOB is mailed to: the patient's (or patient's parent or guardian's) address given on the claim. (**HINT**: Be sure to tell beneficiaries to update their records with current address information.)

Claim Number: Each claim is assigned a unique number to track the claim as it is processed and for reference if there are questions or concerns.

Sponsor SSN/Sponsor Name: Claims are processed using the Social Security Number of the uniformed services service member (active duty, retired, or deceased) who is the TRICARE sponsor.

Beneficiary Name: The individual who received the service/ procedure and for whom this claim was filed.

Benefits Were Payable To: This field appears only if the provider accepts TRICARE assignment. This means the doctor accepts the TRICARE Maximum Allowable Charge (TMAC) as payment in full for the services you received.

Service Provided By/Date of Services: This section lists who provided the care, the number of services and the procedure codes, and the date the beneficiary received the care.

Services Provided: This section describes the medical services received and how many services are itemized (listed) on the claim by listing the specific procedure and diagnostic codes that providers use to identify the specific medical services.

Amount Billed: The amount the provider charged for a particular service(s).

TRICARE Approved: This is the amount TRICARE approved for the services.

See Remarks: If you see a code or a number here, look at the Remarks section (17) for more information about how the claim processed.

Claim Summary: A detailed explanation of the action taken by the claims processor. Here one finds the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) that was already paid to the provider by the beneficiary, amount the other health insurance paid, amount paid to the provider, and amount paid to the beneficiary. A Check Number will appear here only if a check accompanies a TEOB.

Beneficiary Liability Summary: The amount the beneficiary is responsible for paying –may be a deductible, co-payment, cost share, point of service, or non-covered service charges..

Benefit Period Summary: This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense has been paid to date. Claims processors calculate

10.0 Group Activity: Reading an EOB

All Groups: Find the "Learning to Read an Explanation of Benefits (EOB)" guide sheet (section 11.0.) Using the EOB provided on your beneficiary, take a look at the information on the EOB. Pay attention to how it provides the beneficiary information regarding services or care rendered by their provider.

1. **Using the first EOB provided on Jane Smith, answer the following questions:**
    a. What is Jane Smith's status in DEERS?
    b. What is the date of notice on this EOB?
    c. Who provided the care and how much was billed?
    d. What type of provider was this?
    e. What type of care was rendered?
    f. How much does TRICARE cover, and what is the term for this approved amount?
    g. What amount was not covered?
    h. Who is responsible for paying the deductible?
    i. What TRICARE option does Jane Smith use?

2. **Using the second EOB provided on John Doe, answer the following questions:**
    a. Where is the claim number printed on this EOB?
    b. Who rendered the care?
    c. What type of visit was made to the provider?
    d. How much was billed to TRICARE?
    e. How much did TRICARE pay for the service?
    f. How much is the cost share and who pays this?
    g. Which TRICARE option is the beneficiary in?

- Diagnosis is missing
- Third-Party Liability form is required or has not been received
- Other health insurance forms missing
- Complex claim requiring extensive review
- Government directed delay, usually because the provider is being investigated or because of fraud
- Provider delayed submitting claim
- Duplicate charges—more than one claim has been submitted for the same service
- Non-authorized service/no referral
- Medical necessity not documented
- Provider's UIN is missing

9.2 Important to review EOBs

- Beneficiaries should be advised to carefully check each EOB they receive.
- They should make sure they compare their actual bills from the provider or service against the EOB.
- If they find a charge for service they never received, they should contact the claims processor.
- Incorrect charges can be due to a simple error in the provider's billing, or can be an indication of fraud.

9.3 Notes

- The claims processors should be the first source of assistance for any questions pertaining to the EOB.
- The TRICARE Web site refers beneficiaries, who need assistance in completing their claim forms and understanding their Sobs, to their nearest TSC, BCAC, or HBA.
- If an unresolved claims issue is inappropriately sent to a collection agency the beneficiary needs to seek assistance from the nearest regional contractor, TSC, or the nearest DCAO.
- Beneficiary must pay their co-payment, deductibles or point of service charges.

- Can be requested by calling the regional contractor's toll-free number or visiting a local TSC, if one is available
- Can be downloaded from the TRICARE Web site: www.tricare.mil/claims/Dd_2527.pdf
- Can be downloaded from the PGBA's Web site: www.mytricare.com
- Can be downloaded from the WPS' Web site: www.tricare4u.com
- Also available from TSC, BCAC, or HBA

9.0 Explanation Of Benefits (EOB)

After claims are submitted, the beneficiary and provider (if the provider filed the claim) will each receive an EOB from the claims processor showing the services performed and the claim adjudication (or settlement of payments). The EOB will either be mailed physically or it will be posted online on either www.tricare4u.com or www.myTRICARE.com, depending on the region.

9.1 How Soon After Submitting a Claim Should an EOB be Received?

- For the majority (95%) of claims that are able to be processed, the beneficiary and the provider each should receive an EOB within 6 weeks of submitting a claim.
  - Some complex claims may take 60 days to complete.
  - Check the claims processor's Web site or call to determine if a claim has been received.
- In the South region, EOBs are not sent to the beneficiary if they are not liable for charges.
  - However, the beneficiary is encouraged to review all claims information in www.MyTRICARE.com for PGBA and www.TRICARE4u.com for WPS.
- The beneficiary should contact the provider if a TRICARE EOB is not received within the six weeks or if he/she cannot find the claim on the claims processor's Web site. The purpose of the call is to find out if a claim was submitted in a timely fashion.
- Beneficiaries should be aware that EOBs are sent to the address they put on their claims forms in the provider's office or the address their provider has on file.
  - Addresses on claim forms are considered the most recent and accurate information; DEERS is not the primary mailing source for claims.
  - DEERS should be kept updated so that if information is undeliverable, the DEERS address may be used.
- Some reasons for a delay in receiving an EOB:
  - Wrong address
  - Claim is incomplete
  - Eligibility is being questioned/DEERS information inaccurate

- Can be downloaded from the PGBA's Web site: www.mytricare.com
- Can be downloaded from the WPS' Web site: www.tricare4u.com
- Also available from most TSCs and BCACs.

- **UB–04**
  - Used for inpatient or outpatient care from hospitals and other institutes
  - Can be downloaded from the WPS Web site: www.tricare4u.com/apps/tricare2/pdfs/h1450.pdf
  - Can be downloaded from the PGBA Web site: http://www.cms.hhs.gov/providers/edi/h1450.pdf
  - Not readily available at TSCs.

8.3 When Medical Care is Received Overseas

- Beneficiary may submit a DD Form 2642.
- Foreign providers are to submit DD Form 2642
- Very rarely, overseas providers will submit the CMS 1500 or UB-04 forms.

8.4 Items That May Need to be Submitted with Claims

If a beneficiary is required to file the claim, the following may have to accompany the claim:

- Non-availability Statement (NAS) Authorization Number:
  - An NAS is a certification from an MTF stating that it cannot provide the non-emergency inpatient mental health care services sought. If the beneficiary doesn't get an NAS before they receive inpatient behavioral care from a civilian source, TRICARE may not share the costs.
  - The NAS system is now automated. Instead of paper copies of the NASs being sent in with the TRICARE Standard claim, the MTF enters the NASs electronically into the DEERS computer files.
- Itemized list of charges for each service or supply; must be on the provider's letterhead or standard form
- Itemized list of charges from pharmacy; must be on pharmacy's letterhead or billing form
- Other health insurance claims forms: the health plan's payment determination or denial/EOB
- **DD Form 2527**, "Statement of Personal Injury—Possible Third-Party Liability"
  - Required to be submitted with DD Form 2642 when filing in instances in which a beneficiary's condition is accident-related, work-related, or both. The claim processor has certain procedural or diagnostic codes that indicate there may be third party liability involved. Beneficiaries must submit the third party liability form, or else the claim will be denied. This form is initially sent after initial claim.

7.0 Other Health Insurance

Special circumstances exist when beneficiaries have other health insurance (OHI).

- If a beneficiary has OHI, the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE.
- After the OHI has decided what it is going to pay, a claim can then be filed with TRICARE along with a copy of:
  - The other health plan's payment determination
  - The itemized charges (bill)
- If beneficiaries do not tell the regional contractor, the claims processor, or DEERS about their OHI, the claim could be delayed in processing or even denied.

8.0 Claim Forms

Beneficiaries cannot combine different types of claims. They should send a separate claim and claim form for each visit to a provider's office. A separate claim for pharmacy or any other service or supply received should be filed.

Beneficiaries must also submit a separate claim for each family member despite the fact they may have visited the same provider on the same day.

8.1 Sent in by Beneficiaries or Family Members

- **DD Form 2642**, "TRICARE DoD / CHAMPUS Medical Claim - Patient's Request For Medical Payment"
  - Submitted for services or supplies provided by civilian sources of medical care
  - If submitted by a provider, the form will be returned to the provider
  - Can be downloaded from the TRICARE Web site: www.tricare.mil/claims/Dd2642.pdf
  - Can be downloaded from the PGBA's Web site: www.mytricare.com
  - Can be downloaded from the WPS' Web site: www.tricare4u.com
  - Can be requested by calling the regional contractor's toll-free number, or visiting a local TRICARE Service Center, if one is available.
  - As a last resort, beneficiaries may also get claim forms by writing to TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9066.

8.2 Sent in by Providers

- **CMS 1500**, "Health Insurance Claim Form"
  - To be used by professional providers
  - Can be downloaded from the TRICARE Web site: www.tricare.mil/claims/1500-90.pdf

6.0 Who is Responsible for Filing the Claim?

6.1 Network

If the beneficiary sees a network provider, it is the provider's responsibility to make sure that claims are filed.

6.2 Non-Network

- Non-network providers can choose to participate (accept TRICARE payment as payment in full) or not on a case-by-case basis.
- **Participating:**
    - If the provider accepts assignment from TRICARE, they may submit claims for beneficiaries, but ultimately it is the beneficiary's responsibility to make sure that claims get filed.
- **Non- Participating:**
    - The provider is not required to file the claim; it is ultimately the beneficiary's responsibility to make sure that claims get filed.
    - The provider may request that the beneficiary pay 100 percent of the maximum allowable charge up front, however:
        - The maximum amount of reimbursement the provider will receive is 100 percent of the TRICARE allowable charge, plus an additional 15 percent (for Balance Billing.)

6.3 Filing Deadlines

- All claims must be filed within one (1) year of the date of service.
- Beneficiaries should be encouraged to file as soon as possible.
- Recommend to beneficiaries they ask their civilian providers if they will be filing the claims. Beneficiaries are ultimately responsible to ensure claims are submitted to TRICARE for payment.

5.0 Resolving Claims Issues

- The first action beneficiaries should take to resolve claims issues is to call the regional contractor's toll-free number (pick the option for claims assistance) or visit a local TRICARE Service Center.
- If the claim issue remains unresolved, the beneficiary may contact the Beneficiary Counseling and Assistance Coordinators (BCAC) or, if the unresolved debt has resulted in a collection action, contact a Debt Collection Assistance Officers (DCAO).

5.1 Questions to ask the Beneficiary

The following list should be considered when conducting an initial claim inquiry for the beneficiary:

- Did the beneficiary contact the claims processor for their region or plan? If so, what was the result?
- Did the beneficiary bring in his or her explanation of benefits (EOB), summary payment voucher, or bill?
    - If the beneficiary states that he or she never received an EOB, you can look up claims information on the Web (if granted access), or call the processing unit (PGBA or WPS) to determine if a claim was submitted by the provider. If not, call the provider to determine if and when the claim was sent to PGBA or WPS.
- What was the beneficiary's eligibility status or category at the time of service? When was the date of service?
- What type of service was rendered (i.e. medical appointment, Prescription (RX), supplies)?
- Was this service rendered as an inpatient or outpatient?
- If the EOB is available, study the notes to determine why the claim was paid the way it was (i.e. Point of Service [POS], no authorization on file, Social Security Number [SSN] is no longer eligible, not a TRICARE benefit etc.).

5.2 Working with Claims Processors

BCACs and DCAOs should work consistently with one key claims processor staff member to build rapport and maintain consistency in the communication process when researching/resolving beneficiaries' claim(s) issues.

3.0 To Whom are Claims Submitted?

- Claims are submitted to the claims processor responsible for the region in which the beneficiary lives. There are two major TRICARE claims processors:
    - **PGBA** (Palmetto Government Benefits Administrators), which handles claims for the North and South regions.
    - **WPS** (Wisconsin Physicians Service), which handles claims for the West and Overseas regions, as well as all claims for TRICARE for Life (regardless of region).
- If beneficiaries send their claims to the regional contractor instead of the claims processor, the regional contractor will forward it to the appropriate claims processor. If a claim goes to the wrong claims processor, it will be forwarded to the correct processor.
- All TRICARE-eligible beneficiaries are responsible to keep their contact information current with their providers, as well as within DEERS so that their claims go to the correct claims processor.

4.0 Claims Processing Procedures

TRICARE processes claims using specific procedures to ensure:

- All claims are processed in a timely manner, and
- Government-furnished funds are expended only for those services or supplies authorized by law and regulation.

4.1 Processing Criteria

Claims processors verify the following criteria in this order:

1. The beneficiary is eligible.

2. The claim was filed within the given time limits.

3. The provider of services or supplies is TRICARE authorized.

4. The service or supply provided is a benefit.

5. The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.

6. The beneficiary is legally obligated to pay for the service or supply, when appropriate.

7. The claim contains sufficient information to determine the TRICARE allowable charge (TAC) for each service or supply.

Module Objectives

- **Explain who may file claims and to whom they should be submitted**
- **Explain the process involved in beginning to resolve a claim issue**
- **Explain three reasons why a claim may be denied**
- **Recognize what can and cannot be appealed**

1.0 What are Claims for?

Claims are filed to issue payment for services or supplies provided by civilian sources of medical care which may include, but are not limited to:

> Physicians, hospitals, skilled nursing facilities, pharmacies, medical suppliers, ambulance companies, laboratories, physical therapy, vendor pharmacies, Veterans Affairs treatment facilities, other TRICARE authorized providers.

2.0 Who Files the Claim?

The person who submits the claim is either the **provider** of services or supplies, or the **beneficiary**.

2.1 Provider

- Any authorized provider approved under TRICARE for services or supplies provided to a beneficiary and receives payment directly from TRICARE
- Institutional providers include hospitals and nursing facilities
- Professional providers include an independent provider or group practice

Note: TRICARE denies claims from non-authorized providers.

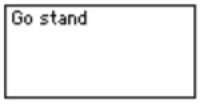
2.2 Beneficiary

- Any TRICARE-eligible beneficiary
    - A spouse, parent, or legal guardian of a minor or incompetent beneficiary may act on behalf of the beneficiary submitting a claim, unless otherwise specified.

Brainteasers

Each of the 8 items below is a separate puzzle.

How many can you figure out?

1. **R | E | A | D | I | N | G**	2. 	3. **LANG4UAGE**	4. 
5. **dice** **dice**	6. **Dribble** **Dribble**	7. GROUND 	8. **FRIENDS STANDING** **FRIENDS** miss

1 **Square dance** _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

How many F's does the following passage contain?

Finished files are the result
of years of scientific study
combined with the experience
of years...

TRICARE Fundamentals Course

Claims & Appeals

14

Participant Guide

References

32 CFR §§ 199.7, 199.10

OPM Part III, Chapter 13

TRICARE Operations Manual 6010.51-M, August 2002, Chapter 8

TRICARE Reimbursement Manual, 6010.53, March 15, 2002, Chap 2, Addendum A

http://www.military.com/benefits/tricare/tricare-standard/non-availability-statements