How to get a Medical Bill removed from a Credit Report by Defense Health Agency Great Lakes (DHA-GL)

Who this is for

Active duty, National Guard, and Reservist

Purpose

To assist members with resolving debt collection issues, the Under Secretary of Defense established Debt Collection Assistance Officer (DCAO) Programs at every Lead Agent Office and Military Treatment Facility worldwide.

DCAOs provide priority assistance when presented documentation verifying that collection action has been started or that negative information is reflected on a member's credit report as a result of late or non-payment for authorized health or dental care received through TRICARE.

Note: While DCAOs cannot provide legal advice or act as beneficiary advocates, they will take all measures necessary to ensure each case is thoroughly researched and that beneficiaries are provided with written findings and assistance in the minimum time possible.

Eligibility

The following personnel may seek assistance via the Defense Health Agency Great Lakes (DHA-GL) DCAO to resolve debt collection issues:

If …	Member MUST …
Active Duty	Be enrolled in TRICARE Prime Remote (TPR) at the time of the authorized care/debt incurred.
National Guard or Reservist	Have been issued a Line of Duty Determination (LOD) at the time of care/debt incurred. Note: The LOD must be on file at DHA-GL prior to requesting assistance. See "How to Forward Medical Eligibility Documentation (Line of Duty Determination LOD) to DHA-GL" process guide for complete instructions.

How to Request Assistance Follow these steps to receive assistance from the DHA-GL Debt Collection Assistance Office (DCAO):

Step	What Happens
1	Member completes the following forms (located at the end of this section): • Authorization For Disclosure of Medical or Dental Information DD Form 2870 • Notice of the Role of the DCAO form Note: DHA-GL must have these forms to legally contact the credit bureau and/or collection agencies involved.
2	Member faxes or mails the following documentation to DHA-GL DCAO: • DD Form 2870 • Notice of the Role of the DCAO form • Copy of the final notice letter from the collection agency/credit bureau, stating this information has been noted on the member's credit report • LOD (if appropriate) **FAX: 847-688-6460** Mailing Address: Defense Health Agency Great Lakes DHAGL Attn: Debt Collection Action Officer (DCAO) Bldg 3400 Ste 304 2834 Green Bay Road Great Lakes IL 60088 Note: If the DHA-GL DCAO does not receive all the information listed above from the member, the DCAO will send the member a letter requesting information needed to pursue the case.

Results and Follow-up

Once a complete package is received, the DHA-GL DCAO will contact the credit bureau/collection agency and requests a 60-day hold until TRICARE pays the claim. Once paid by TRICARE, a notice goes to the credit bureau/ collection agency with information pertaining to the date of the check and check number. The letter also requests that the negative credit information be removed within 14 days.

If the care in question is not covered by TRICARE, or the member was ineligible, the DHA-GL DCAO will send a letter to the member stating the facts.

Website

Contact information for DCAOs can be found on the TRICARE web site at: https://tricare.mil/bcacdcao

Enclosures

- Notice of the Role of the DCAO form
- Authorization For Disclosure of Medical or Dental Information DD Form 2870

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Section	Military Medical Support Office
Position	Customer Service Representative
Phone	888-647-6676
	For questions about:
Billing/Claims	Dial option 2 then option 3
Pre-	Dial option 1 then option 3
Fax	847-688-6460 or 847-688-7394

Privacy Act Statement: This statement serves to inform you of the purpose for collecting information required by the Defense Health Agency Great Lakes (DHA-GL) and how it will be used. **AUTHORITY**: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE program; and E.O. 9397 (SSN), as amended. **PURPOSE**: To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program. **ROUTINE USES**: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 522a (b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPPA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by 6025.18-R. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations. **DISCLOSURE**: Voluntary; however, failure to provide information may result in the denial of coverage.

DEFENSE HEALTH AGENCY – GREAT LAKES

DEBT COLLECTION RESOLUTION PACKET

INSTRUCTIONS FOR COMPLETING THE DD2870 FOR DEBT COLLECTION

1. **On the DD Form 2870 complete Section I in its entirety.**
2. **In Section II please indicate the name of the collection agency in Block #6.**
3. **In Block #9 please use today's date.**
4. **Leave Block #10 blank**
5. **In Section III, Sign and date the form**
6. **Please attach a copy of the collection notice or credit report as well as any medical claims for this episode of care.**

Debt Collection Checklist (Please check what you are returning)

☐**This coversheet completed**
☐**Acknowledgement Sheet of Debt Collection Assistance Officer**
☐**DD Form 2870… Completed as stated above**
☐**Copy of Collection notice or Credit Report showing the delinquency**
☐**Medical Claims/bills for this episode of care**
☐**Documents substantiating the duty status of the service member**
☐**Other supporting documentation that may support the claim**

Fax To: **Debt Collection Assistance Officer** **Fax Number: 847-688-6460** **Phone number: 888-647-6676 opt 2, opt 3**	**Submitted by:** **Phone Number:**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.a
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1.a NAME *(Last, First, Middle Initial)*	2.a DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBERa

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5.a TYPE OF TREATMENT *(X one)*
	[ ] OUTPATIENT [ ] INPATIENTa [ ] BOTH

SECTION II - DISCLOSURE

6.a I AUTHORIZEa _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a.a NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b.a ADDRESS *(Street, City, State and ZIP Code)*
D.Sharp,d.. Maravola, D.Anderson, A. Jackson, V. Bell, N. Hendersona	2834 Greenbay Rd, BLDG 3400, Ste 304 Great Lakes IL 60088
b.a TELEPHONE *(Include Area Code)* (847) 688-3950	d.a FAX *(Include Area Code)* (847) 688-6460a

7.a REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE	[ ] CONTINUED MEDICAL CARE	[ ] SCHOOLa	[ ] OTHER *(Specify)*
[X] INSURANCE	[ ] RETIREMENT/SEPARATION	[ ] LEGAL	

8.a INFORMATION TO BE RELEASEDa
Medical claims and supporting documents

9.a AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATIONa	
	[ ] DATE *(YYYYMMDD)*	[X] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a.a I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facilitya where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by thea TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b.a If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c.a I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.a
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, paymenta by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11.a SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVEa	12.a RELATIONSHIP TO PATIENTa *(If applicable)*	13.a DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14.a X IF APPLICABLE:a	15.a REVOCATION COMPLETED BYa	16.a DATE *(YYYYMMDD)*
[ ] AUTHORIZATIONa REVOKED		

17.a IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME:a SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

NOTICE OF THE ROLE OF THE DEBT COLLECTION ASSISTANCE OFFICER

ACKNOWLEDGEMENT

I,_____,understand that the role of the Debt Collection Assistance Officer (DCAO) is one of researching TRICARE claims that are the basis for an underlying debt. The DCAO has my consent to contact all necessary agencies – including military personnel offices, military treatment facilities (MTF), TRICARE Lead Agent offices, the TRICARE Management Activity (TMA), managed care support contractors, creditors who have issued bills, even debt collection agencies if appropriate – in order to research the TRICARE claim involved. The DCAO will assist me in understanding the basis for the underlying debt. The DCAO will coordinate with TMA to provide an official determination as to the appropriate resolution of a TRICARE claim.

I acknowledge and understand that the DCAO is NOT acting as my advocate in assisting me regarding the pending debt collection action. In addition, I acknowledge that the DCAO is NOT acting as my legal representative in this matter. In the event the DCAO determines that the debt appears to be valid, I have the right to continue to challenge the correctness of the debt, including exercising my TRICARE appeal rights. I understand I have the right to seek legal assistance through my legal assistance officer or private attorney.

_____ Date: _____

_____

PRINTED NAME AND SOCIAL SECURITY NUMBER

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