Defense Health Agency Great Lakes

(DHA-GL)

Process Guide

February 2019

DEFENSE HEALTH AGENCY GREAT LAKES (DHA-GL) Process Guide

This guide was developed to assist active duty, reservist, guard members, unit medical and command representatives with commonly used DHA-GL services (or processes).

How to Forward Medical Eligibility Documentation to Defense Health Agency Great Lakes DHA-GL

Who this is for

National Guard and Reservist

Purpose

Medical eligibility documents are used to document, establish, manage, and authorize civilian health care for eligible Reservist and National Guard members who incur or aggravate an injury, illness or disease in the line of duty.

Defense Health Agency Great Lakes (DHA-GL) is responsible for the authorization of civilian medical care for Reservist and National Guard members who are NOT in the catchment area of a Military Treatment Facility (MTF).

Eligibility

Reservist and National Guard members who incur or aggravate an injury, illness or disease in the line of duty.

Submitting Eligibility

Follow these steps to forward medical eligibility documentation to DHA-GL:

Steps	Action
1	Unit medical representative completes DHA-GL Medical Eligibility Request – DHA-GL Medical Eligibility Verification Worksheet DHAGL Worksheet 01 (select from list under Request Worksheets).
2	**Army Reserve and Army National Guard must submit eligibility through eMMPS/Medchart.** Unit medical representative, for all other branches of service, faxes or mails a copy of orders or drill attendance sheet along with DHA-GL Medical Eligibility Verification Worksheet DHAGL Worksheet 01 to the following FAX or address: • **FAX: 847-688-6460 or 847-688-7394** Mailing Address: Defense Health Agency Great Lakes (DHA-GL) Attn: Reserve Eligibility Bldg 3400 STE 304 2834 Green Bay Road Great Lakes IL 60088A

3	Ensure provider submits claims to appropriate region and uses the service members SSN as the member ID number on the medical claim. Tricare East Tricare East Region Claims New Claims P.O. Box 7981 Madison, WI 53707-7981 Tricare West Tricare West Region Claims Submission Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 202112 Florence, SC 29502-2112

Steps	Action
	Note: If a service member needs follow-up medical care, please see DHA-GL Process Guide – "How to Request Pre-Authorization for Line of Duty (LOD) Medical Care" (select from list under Instructions)

Results and Follow-up

After the required medical eligibility documents have been submitted to DHA-GL for the initial episode of care, units can request a pre-authorization for follow up medical care through the DHA-GL Line of Duty Section. The request must include a **Service Approved** Line of Duty. Any Claims for medical care rendered without a pre-authorization will be denied.

Link

DHA-GL Medical Eligibility Request - DHA-GL Medical Eligibility Verification Worksheet DHAGL Worksheet 01 (select from list under Request Worksheets).

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
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 DHA-GL Worksheet-01 Rev. 04/10/2017	**MEDICAL ELIGIBILITY VERIFICATION:** RESERVE COMPONENT

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then faxes or mails this form and supporting documentation to DHA-GL.
Complete ALL Blocks

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the Defense Health Agency Great Lakes 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.

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DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of coverage.

Defense Health Agency - Great Lakes DHA-GL Worksheet-01 Rev. 04/10/2017	**MEDICAL ELIGIBILITY VERIFICATION:** RESERVE COMPONENT

Instructions: Member or current unit representative completes Sections I and II. Unit representative completes and validates Section III; faxes or mails this form and supporting documentation to DHA-GL (FAX number / address below).

COMPLETE ALL BLOCKS

Section I Member Data

1. Branch of Service: ◯USAR ◯USNR ◯USMCR ◯USAFR ◯ARNG ◯ANG ◯USCGR

2. Name (Last, First, MI):	3. Rank or Grade:	4. SSN:
5a. Address (street, apt #, city, state, & zip):		6. DOB (YYMMDD):
5b.Member Email Address:		7. Phone # (include area code):

Section II Illness/Injury Information

8. Date of injury/illness (YYMMDD):	9. Treated on (YYMMDD):	10. Duty Dates (YYMMDD): 10a. From: 10b.To:

11. Diagnosis or description of injury/illness and/or pharmacy claim (include DRG and/or ICD-10 Code):

Section III Current Unit Certification of Eligibility

12. Type of ORDERS: ◯ Weekend Drill ◯ Annual Training ◯ Other

13. Name of the nearest Military Treatment Facility:_____which is ____ miles from the member's. ◯ place of duty or ◯ residence

14a. Unit Assignment (unit name, staff symbol, code, etc.):	14b. Unit UIC/OPFAC:
14c. Unit Address (street, bldg #, city, state, & zip):	14d. Unit Phone # (include area code):
15a. Unit POC - Medical Rep/Unit Administrator (name, rank and title):	15b. POC Phone # (include area code):
15c. Unit POC Department of Defense email address (.mil):	

16. **Certification**: I certify that this individual is eligible for care at government expense (CO or Medical Rep. signature):

Signature Printed Name: Date:

STOP Include all required documents!

You **must attach** the following:	**FAX or Mail Information:**
Drill Attendance Sheet or Orders (for initial date of medical care) Documents must match or cover the dates in block 8 above	**FAX** this form/attachments to: **847-688-6460 or 7394** **OR** **MAIL** this form/attachments to: Defense Health Agency Great Lakes (DHA-GL) Attn: Reserve Eligibility 2834 Green Bay Road Ste 304 Great Lakes, IL 60088

How to Submit a Request for Pre-authorization for Line of Duty (LOD) Medical Care to DHA-GL

Who this is for

National Guard and Reservist

Background and Purpose

Defense Health Agency Great Lakes (DHA-GL) is responsible for pre-authorizing all civilian medical care for eligible National Guard and Reservist who have been injured or became ill in the line of duty during a period of qualified duty and **are not in the catchment area** of a Military Treatment Facility (MTF).

Eligibility

You must meet the following criteria:

- National Guard or Reservist and have been issued a Line of Duty Determination (LOD) and are not in the catchment area of a MTF.
- Have medical eligibility documentation on file at DHA-GL prior to requesting care. See DHA-GL process guide "How to Forward Medical Eligibility Documentation to DHA-GL" for complete instructions.

Filing Process

Follow these steps to receive pre-authorization for civilian health care:

Step	Action
1	**Member or unit medical representative** finds a Network Provider who can provide the care. NOTE: Call your Regional TRICARE Contractor or www.tricare.mil/welcome to locate a Network Provider.
2	Unit medical representative completes a **Pre-Authorization Request for Medical Care** DHA-GL Worksheet-02 (select from drop-down box under Request Worksheets). Most authorizations will be completed for evaluate and treatment. If evaluate and treatment may not be warranted in a certain case, please contact DHA-GL. Exceptions to evaluate and treatment authorization will be considered on a case by case basis.

Step	Action
3	Unit medical representative faxes or mails DHA-GL Worksheet-02, service approved LOD, clinical documentation, profile information (if applicable) and DHA-GLWorksheet-06 (if applicable) to the following FAX or address: **NOTE:** All Army National Guard and Army Reserve requests are required by the National Guard Bureau and OCAR to be submitted by the Electronic Medical Processing System (eMMPS/MedChart). Ref: NGB-ARP memo, dtd 3 Feb 06, subj: Army National Guard (ARNG) Line of Duty (LOD) Module. ARNG LOD Module at https://medchart.ngb.army.mil/LOD. • **FAX: 847-688-7394** **Mailing Address**: Defense Health Agency Great Lakes (DHA-GL) Attn: Medical Pre-Authorizations Bldg 3400 Ste 304 2834 Green Bay Road Great Lakes IL 60088

Line of Duty (LOD) Episode of Care (EOC) Authorizations

Effective 09-04-2018 for the TRICARE East region and 11-15-2018 for the TRICARE West region, most LOD follow-on care pre-authorizations issued by THP MMSO (Defense Health Agency, Great Lakes) are 180 day EOC authorizations. These are defined as a authorizations for evaluation and treatment of a specific LOD medical condition to include diagnostic tests, durable medical equipment support, treatment (to include surgery, if indicated) and any required/related follow on care to include physical therapy, follow-on testing, etc. There is no longer a requirement for incremental requests to authorize care for each step in the treatment process. EOC authorizations result in a better coordinated treatment process for the RC service member and reduces delays in providing needed care.

Under EOC, often referred to as "Primary Care Manager (PCM) evaluate and treat," the PCM manages the entire episode of care to include diagnostics, treatment and follow-on care. The PCM initiates the referral/preauthorization request directly to the respective TRICARE managed care support contractor through the provider referral/authorization portal. Once the TRICARE contractor receives the referral, they provide an authorization directly to a specialty provider for the specialty services requested by the PCM. This process occurs independently of THP MMSO and the Unit. The member and/or the unit may see these authorizations once completed on the TRCARE Contractor's authorization self-service portal (provide URLs). **It is the Service member's responsibility to keep the Unit informed on the status of their care throughout the entire EOC treatment process.**

After the initial six month authorization period is completed, if more care is needed, the RC service member should inform their Unit. The Unit may, then, request another 180 day EOC authorization from THP MMSO.

There may be rare occasions when the initiation of a short-term incremental authorization for a specific diagnostic evaluation, test, or procedure may be warranted. These cases will be reviewed and authorized by THP MMSO on a case-by-case basis.

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
Fax	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 DHA-GL Worksheet-02 Rev. 05/31/2018	**PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE:** RESERVE COMPONENT

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then faxes or mails this form and supporting documentation to DHA-GL.
Complete ALL Blocks

PRIVACY ACT STATEMENT

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Defense Health Agency - Great Lakes
DHA-GL Worksheet-02
Rev. 05/31/2018

PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE: RESERVE COMPONENT

Instructions: Member or current unit representative completes Sections I and II. Unit representative completes and validates Section III; faxes or mails this form and supporting documentation to DHA-GL.
COMPLETE ALL BLOCKS

Section I Member Data

1. Branch of Service: ◯USAR ◯USNR ◯USMCR ◯USAFR ◯ARNG ◯ANG ◯USCGR

2. Name (Last, First, MI):	3. Rank or Grade:	4. Full SSN:
5a. Address (street, apt #, city, state, & zip):	6. DOB (YYMMDD):	7. Phone # (include area code):
5b. Member email address:	8. TRICARE Region ◯East ◯West ◯Unknown	

Section II Pre Authorization Request

9. Date of injury/illness (YYMMDD):	10. Duty Dates (YYMMDD): 10a. From: 10b.To:

11. Diagnosis (Include ICD-10 Code):

12. Sent eligibility documents to DHA-GL on:_____.
If not sent, check which documents are attached (one or both): ◯ Line of Duty form (LOD) ◯ Orders/Attendance Roster.

13. List needed follow-up care or durable medical equipment (include CPT/HCPCS codes):

14. Is a Medical Board in Process? ◯Yes ◯ No **If yes, note start date and Military Hospital/Clinic name:**

Section III Current Unit Certification of Eligibility

15. Name of the nearest Military Treatment Facility which is _____ miles from the member's. ◯place of duty or ◯residence

16a. Unit Name & Address (Unit name, staff symbol, code, etc.):	16b. Unit UIC/OPFAC:
17a. Unit POC - Medical Rep/Unit Administrator(Name, Rank and Title):	17b. POC Phone # (include area code):
17c. Unit POC United States Department of Defense email address (.mil):	

18. **Certification**: I certify this individual is eligible for this care at government expense (CO or Medical Rep. signature):
Signature Printed Name: Date:

STOP Include all required documents!

You **must attach** the following:

Service Approved LOD and Clinical Documentation

Documents must match or cover the dates in block 9 above

FAX or Mail Information:

FAX this form/attachments to:

847-688-7394 or 6369 **OR**

MAIL this form/attachments to:

Defense Health Agency Great Lakes (DHA-GL)
Attn: Reserve Eligibility
2834 Green Bay Road Ste 304
Great Lakes, IL 60088

How to Submit a Formal Appeal to Defense Health Agency Great Lakes DHA-GL

Who this is for Active duty, National Guard, and Reservist

Purpose This explains how an eligible member submits a formal appeal to the Defense Health Agency Great Lakes (DHA-GL) to request:

- Payment of a denied authorized medical care claim
- Approval of a pre-authorization for medical care previously denied

Eligibility To be eligible to submit a formal appeal to DHA-GL you must have been either denied a payment of medical care claim(s), or denied pre-authorization request(s) for authorized medical care, and meet the following criteria:

If …	Then on date of care, MUST …
Active Duty	Be eligible in Defense Enrollment Eligibility Reporting System (DEERS), and **not** TRICARE enrolled to an MTF.
National Guard or Reservist	Have an approved Line of Duty (LOD) on file at DHA-GL for the illness or injury.

Definition: Authorized health care: A medical treatment or procedure which is medically necessary.

Appeal Process Follow these steps to submit a formal appeal to DHA-GL:

Step	Who does it	What Happens
1	Member	Contacts Medical/Unit Representative for clarification, guidance, and assistance with denial of claim or pre-authorization request.
2	Member/Unit Representative	Ensures the denial decision was made by DHA-GL and not by a Military Treatment Facility (MTF) and is authorized health care. **Note**: If the member's care is managed by an MTF, contact that MTF for appeal process.
3	Medical/Unit Representative	Contacts appropriate DHA-GL point of contact below via telephone or mail for further information regarding the reason for denial.
4	Member/Unit Representative	Assists member in developing and mailing the appeal request package.
5	Member	Completes and mails the following appeal request package to DHA-GL at the below address: • Copy of the Explanation of Benefits (EOB), if applicable • If Reservist, copy of orders and/or applicable LOD (if not on file at DHA-GL) **Mailing Address**: Defense Health Agency Great Lakes (DHA-GL) Attn: Appeals Bldg 3400 Ste 304 2834 Green Bay Road Great Lakes IL 60088 Fax: 847-688-6460

Results and Follow-up

If the appeal is denied, the reason for the denial and information on how to initiate a second level appeal will be provided in writing directly to the service member.

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
Fax	847-688-6460

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FORMAL APPEAL REQUEST
Defense Health Agency Great Lakes DHAGL

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Defense Health Agency Great Lakes DHAGL only. See the DHAGL website for detailed instructions at http://www.tricare.mil/tma/greatlakes/

PRIVACY ACT STATEMENT

Privacy Act Statement

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PURPOSE: To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program.

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DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of coverage.

Defense Health Agency - Great Lakes DHA-GL Worksheet 03 Rev. 06/01/2014	**FORMAL APPEAL REQUEST** **Defense Health Agency Great Lakes DHAGL**

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Defense Health Agency Great Lakes only. See the DHAGL website for detailed instructions at http://www.tricare.mil/tma/greatlakes/

1. Branch of Service *(please ✓ one)*
☐ USA ☐ USAF ☐ USN ☐ USMC ☐ ANG ☐ USCG
☐ USAR ☐ USAFR ☐ USNR ☐ USMCR ☐ ARNG ☐ USCGR

2. Name (last, first, MI):	3. Rank or Grade:	4. SSN (full)

5. Duty Location (Unit name and location)	6. Daytime Phone # & Personal Email

7. Type of Appeal *(please ✓ one)*: ☐ Denied Claim ☐ Denied Pre-authorization Request

8. Date of Injury/Illness (YYMMDD):	9. Date(s) of Care/Pre-authorization request (YYMMDD):

10. Unit/Command Medical POC:	10A. POC Phone # (include area code)

11. Appeal: Briefly state why the claim should be paid, or the denied pre-authorization should be approved:

Patient Signature:	Date Signed

Pharmacy Reimbursement for Guard and Reservist with Line of Duty (LOD) injuries or illness - DHA-GL

Who this is for

National Guard and Reservist

Background

Defense Health Agency Great Lakes DHA-GL in conjunction with Express Scripts Incorporated (ESI) began processing Retail Pharmacy reimbursements for National Guard and Reservist on 15 November 2004.

Eligibility

National Guard and Reservist who have pre-paid or have been billed for pharmaceuticals in conjunction with a Line of Duty Determination (LOD) injury or illness.

Note: Over-the-counter drugs and any non-covered pharmaceuticals will not be reimbursed.

Process for Reimbursement

Follow these steps to get reimbursed for authorized pharmaceutical items:

Step	What Happens
1	Member/Designated person with a Power of Attorney ONLY completes and signs a CHAMPUS Claim - Patient's Request for Medical Payment DD Form 2642.
2	Member provides claim printout or paid civilian pharmacy invoice with the following information: • Doctors Name • Drug Name • National Drug Code(NDC) number • Quantity • Cost share or amount charged • Date of service, and • Name of Retail Pharmacy and address (required)
3	Obtain eligibility documentation that covers the date of injury and/or pharmacy, i.e. orders, attendance roster, or LOD if not already sent to/ on file at DHA-GL.

Step	What Happens
4	Complete DHA-GL Medical Eligibility Verification worksheet (DHAGL Worksheet 01 - select from list under Request Worksheets). **Write pharmaceutical reimbursement as well as diagnosis in block #11.**
5	Forward the DD Form 2642, pharmacy invoice, eligibility documentation/LOD, and DHA-GL Medical Eligibility Verification Worksheet to the following FAX or address: • **FAX: 847-688-6460** **Mailing Address**: Defense Health Agency Great Lakes (DHA-GL) Attn: RC Retail Pharmacy Reimbursement Bldg 3400 Ste 304 2834 Green Bay Road Great Lakes IL 60088

Results and Follow-up

If DHA-GL determines your pharmacy bill is related to your LOD injury or illness they will instruct ESI to process your claim for reimbursement. Within 30 working days, you will receive an Explanation of Benefits (EOB) statement with a reimbursement check from ESI.

Website

TRICARE website for TRICARE Pharmacy Program - http://www.tricare.mil/pharmacy

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
Fax	847-688-6460

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- PATIENT'S COPY -

TRICARE DoD/CHAMPUS MEDICAL CLAIM
PATIENT'S REQUEST FOR MEDICAL PAYMENT

OMB No. 0720-0006
OMB approval expires
Aug 31, 2009

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.

PRIVACY ACT STATEMENT

AUTHORITY: 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.
PRINCIPAL 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 Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection 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 CHAMPUS.
DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

IMPORTANT - READ CAREFULLY

Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT

NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a bona fide emergency. Without a necessary NAS your claim will be denied.

* * * * * *

ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

DRUGS: Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available; the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.

* * * * * *

TIMELY FILING REQUIREMENTS: All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadiline, or within 90 days of the notice -- whichever date is later.

* * * * * *

WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity, 16401 E. Centretech Pkwy., Aurora, CO 80011-9066.

* * * REMINDER * * *

Before submitting your claim to the claims processor be sure that you have:

1. **Completed all 12 blocks on the form.** *If not signed, the claim will be returned.*
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required (see information above).
6. Attached DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side.
7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.

- 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.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?
☐ 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.

TRICARE DoD/CHAMPUS MEDICAL CLAIM
PATIENT'S REQUEST FOR MEDICAL PAYMENT

OMB No. 0720-0006
OMB approval expires
Aug 31, 2009

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.

PRIVACY ACT STATEMENT

AUTHORITY: 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.
PRINCIPAL 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 Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection 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 CHAMPUS.
DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

IMPORTANT - READ CAREFULLY

Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT

NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a bona fide emergency. Without a necessary NAS your claim will be denied.

* * * * * *

ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

DRUGS: Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available; the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.

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5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)*

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7. IS PATIENT'S CONDITION *(X both if applicable)*
ACCIDENT RELATED? ☐ YES ☐ NO
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8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.

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b. **TYPE OF COVERAGE** *(Check all that apply)*
☐ *(1)* EMPLOYMENT *(Group)* ☐ (3) MEDICARE ☐ *(5)* MEDICARE SUPPLEMENTAL INSURANCE ☐ (7) OTHER *(Specify)*
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	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.

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a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?
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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).
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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.

How to Get Reimbursed for Pre-Paid Out-of-Pocket Medical Bills Defense Health Agency Great Lakes (DHA-GL)

Who this is for Active duty, National Guard, and Reservist

Purpose This topic explains how an eligible member can get reimbursed for authorized medical care that was pre-paid out-of-pocket.

Eligibility Active duty, National Guard and Reservist who pre-pay for authorized medical care or out-of-pocket costs must meet the following eligibility criteria:

If …	Then on date of care/bill, MUST …
Active Duty	Be eligible in Defense Enrollment Eligibility Reporting System (DEERS), and enrolled to the appropriate Primary Care Manager. Note: Errors in the DEERS database can cause problems with TRICARE claims, so it is critical to maintain your DEERS information. See "DEERS Enrollment" section below.
National Guard or Reservist	Have a service endorsed Line of Duty (LOD) on file at Defense Health Agency Great Lakes (DHA-GL) for the illness or injury.

Note: To be reimbursed all health care must be a covered benefit or medically necessary.

Reimbursement Process Follow these steps to submit a request for reimbursed for pre-paid medical bills:

Step	What Happens
1	Member completes and signs a CHAMPUS Claim - Patient's Request for Medical Payment, DD Form 2642
2	Forward the DD Form 2642, bill, and proof of payment (i.e. copy of paid receipt, cancelled check, credit card statement, etc.) to the appropriate Managed Care Contractor for your region as follows: **West Region:** TRICARE West Claims Submission Health Net Federal Services, LLC C/O PGBA, LLC/TRICARE PO Box 202112 Florence, SC 29502-2112 FAX: 1-844-869-2504 Toll Free: 1-800-866-9378 https://www.tricare-west.com **East Region:** TRICARE East Region Claims P. O. Box 7981 Madison, WI 53707-7981 Fax: 1-608-221-7536 Toll Free: 1-800-444-5445 https://www.humanamilitary.com

Results and Follow-up When the appropriate documentation is received and processed by the Regional Managed Care Contractor a payment decision will be reflected on an Explanation of Benefits (EOB), normally within 30 working days of receipt.

Websites and References

TRICARE Resources Medical Claims
http://www.tricare.mil/Resources/Claims/MedicalClaims.aspx
TRICARE Operations Manual, chapter 19, Sections 1.4.1 and 3.8.3.

DEERS Enrollment

Follow one of the steps below to update your information in DEERS:

In person	Go to the nearest military personnel office or uniformed services ID card-issuing facility
Online	DEERS Website https://www.dmdc.osd.mil/milconnect/
By Mail	Defense Manpower Data Center Support Office Attention: COA 400 Gigling Road Seaside, CA 93955-6771
Fax	DEERS 831-655-8317
Phone	800-538-9552 Monday-Friday, 6 a.m. to 3:30 p.m. PST

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
Fax	847-688-6460

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.

- PATIENT'S COPY -

TRICARE DoD/CHAMPUS MEDICAL CLAIM
PATIENT'S REQUEST FOR MEDICAL PAYMENT

OMB No. 0720-0006
OMB approval expires
Aug 31, 2009

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ROUTINE USE(S): Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection 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 CHAMPUS.
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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.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY? ☐ 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.

TRICARE DoD/CHAMPUS MEDICAL CLAIM
PATIENT'S REQUEST FOR MEDICAL PAYMENT

OMB No. 0720-0006
OMB approval expires
Aug 31, 2009

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.

PRIVACY ACT STATEMENT

AUTHORITY: 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.
PRINCIPAL 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 Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection 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 CHAMPUS.
DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

IMPORTANT - READ CAREFULLY

Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT

NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a bona fide emergency. Without a necessary NAS your claim will be denied.

* * * * * *

ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

DRUGS: Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available; the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.

* * * * * *

TIMELY FILING REQUIREMENTS: All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadiline, or within 90 days of the notice -- whichever date is later.

* * * * * *

WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity, 16401 E. Centretech Pkwy., Aurora, CO 80011-9066.

* * * REMINDER * * *

Before submitting your claim to the claims processor be sure that you have:

1. **Completed all 12 blocks on the form.** *If not signed, the claim will be returned.*
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required (see information above).
6. Attached DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side.
7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.

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.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?
☐ 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.

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: • 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	Debt Collection Assistance Officer (DCAO)
Phone	888-647-6676
Fax	847-688-6460

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.
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. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* [ ] OUTPATIENT [ ] INPATIENT [ ] BOTH	

SECTION II - DISCLOSURE

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

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
Defense Health Agency - Great Lakes	2834 Grccnbay Rd, BLDG 3400, Ste 304 Great Lakes IL 60088
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

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

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

8. INFORMATION TO BE RELEASED

Medical claims and supporting documents

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

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the 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. 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. 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.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Planor eligibili ty 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. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

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

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

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

Reset

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

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.