FIGURES

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FIGURE 12-12.2-1 HOST NATION NETWORK PROVIDER FORM

(Please type or print legibly)

Host Nation Provider Name:_____

Address:
(actual place of business)
_____
_____
_____
_____

Phone Number: (_____)_____

Fax Number: (_____)_____

Provider Major Specialty: _____

Mailing Address:
(Please indicate address to which checks should be mailed.)
_____
_____
_____
_____

Comments:
_____
_____
_____
_____

****

Approved by:_____**Effective Date:**_____
_____
_____
_____

Date:_____

Managed Care Contractor Assigned Provider Number:_____

FIGURE 12-12.2-2 COVER LETTER FOR TRANSMITTING TRICARE OVERSEAS PROGRAM NON-AUTHORIZED CLAIMS REPORT TO TRICARE AREA OFFICE (TAO) DIRECTOR (SAMPLE)

(TAO Director Name)
(**Address**)
(**Address**)

Dear _____:

Enclosed is the weekly report of non-authorized claims received without authorization from TRICARE overseas enrollees.

Please review and indicate approval as appropriate. Please return the completed report and sign the authorization below. Upon receipt of the report, we will reprocess these claims according to your directions.

Please return the authorization to:

(**Name - Managed Care Contractor Representative**)
(**Name - Managed Care Contractor**)
(**Address**)
(**Address**)

Sincerely,

(**Contractor Representative**)

Authorized Signature:

The attached claims listing is approved as noted for reprocessing.

Signature _____

Title _____

Date _____

FIGURE 12-12.2-3 TAO DIRECTOR HOST NATION NON-AUTHORIZED OR HOST NATION NON-NETWORK PROVIDER CLAIMS REPORT

	SPONSOR	PATIENT	SPONSOR	HOST NATION PROVIDER		HCDP DMIS			PURPOSE	REASON FOR REFERRAL*		APV.	
ICN	LAST 4 DIGITS SSN	NAME	NAME	NAME AND ADDRESS	DATES	ID CODE	ICD9	CPT[1] CODE	VISIT	A	P	Y	N
97360 DE 00001	123 45 6789	Smith, Ann S.	Smith, John M.	Bauman, Peter HERDSTR 13 Donauschingn De	11-01-97-11-15-97								
97360 GB 00002	987 65 4321	Jones, Sally	Jones, Tom M.	Shepherd, Cameran *4TROON Dr Bridge of Weir GB	11-02-97-11-05-97								

* A = Authorization
P = Host Nation Non-Network Provider

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FIGURE 12-12.2-4 LIST OF OVERSEAS REMOTE, NON-REMOTE, & MTF COUNTRIES BY REGION

TRICARE EUROPE	TRICARE EUROPE	TRICARE EUROPE
Afghanistan	Greece	Poland
Albania	Greenland	Portugal (Azores)*
Algeria	Guinea, Republic of	Qatar
Andorra	Guinea-bissau	Romania
Angola	Hungary	Russia
Armenia	Iceland*	Rwanda
Austria	Iran	St. Helena (Ascention Island)
Azerbaijan, Republic of	Iraq	St. Pierre and Miquelon
Bahrain, Kingdom of	Iraq (includes Saudi Arabia and Neutral Zone)	Saotane an Principe
Belarus	Ireland	San Marino
Belgium*	Isle of Mann	Senegal
Benin	Israel	Serbia and Montenegro
Bosnia and Herzegovina	Italy*	Seychelles
Botswana	Ivory Coast (Cote D' Ivoire)	Sierra Leone
Bowet (Bouvel) Island	Jordan	Slovakia
Bulgaria	Kazakhstan	Slovenia
Burkina-faso	Kenya	Somalia Republic
Burundi	Kuwait	South Africa
Cameroon	Kyrgyzstan	Spain*
Cape Verde Island	Latvia	Sudan
Central Africa Republic	Lebanon	Svalbard and Jan Mayan
Chad	Lesotho	Swaziland
Comorus	Liberia	Sweden
Congo (Brazzaville)	Libya	Switzerland
Croatia	Liechtenstein	Syria
Cyprus	Lithuania	Tajikistan
Czech Republic	Luxembourg	Tanzania
Democratic Republic of Kongo	Macedonia	Togo
Denmark	Malawi	Tunisia
Djibouti	Mali	Turkey*
Egypt (United Arabian Emirates)	Malta	Turkmenistan
Equatorial Guinea	Mauritania	Uganda
Eritrea	Moldova	Ukraine
Estonia	Monaco	United Arabian Emirates
Ethiopa	Morocco	United Kingdom (includes Isle of Man, Guernsey, and Jersey)*
Faroe Island	Mozambique	Uzbekistan
Finland	Namibia	Vatican City (Holy City)
France (includes Ile Europa)	Netherlands	Western Sahara (Port of Morocco)
Gabon	Niger	Yemen
Gambia	Nigeria	Yugoslavia
Georgia	Norway	Zaire
Germany*	Oman	Zambia
Ghana	Pakistan	Zimbabwe
Gibraltar		
Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.	**Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.**	**Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.**

FIGURE 12-12.2-4 LIST OF OVERSEAS REMOTE, NON-REMOTE, & MTF COUNTRIES BY REGION (CONTINUED)

TRICARE PACIFIC
American Samoa
Antartica
Australia
Bangladesh
Bhutan
British Indian Ocean
Brunei
Burma
Cambodia (Kampuchea)
China, (Peoples Republic of) (includes Paracel and Spratly Islands)
Christmas Island (Indian Ocean)
Cocos Island (Indian Ocean)
Cook Island
Fiji, Republic of
French Polynesia
French Southern & Antartic Lands
Guam
Heard and McDonald Islands
Hong Kong, Special Administrative Regions of China
India
Indonesia
Japan (Includes Ryukyus)*
Kiribati
Korea (includes North and Republic)*
Laos
Macao
Madagascar (Malagasy Republic)
Malaysia
Maldives
Marshall Islands
Maurititus
Mayotte
Micronesia
Mongolia
Myanmar
Naura
Nepal
New Caledonia
New Zealand

Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.

TRICARE PACIFIC
Niue
Norfolk Island
Northern Mariana Islands (includes Saipan)
Papua and New Guinea
Philippines
Pitcairn
Republic of Palau
Reunion
Singapore
Solomon Islands
Sri Lanka (Ceylon)
Taiwan
Thailand
Tokelau Island
Tonga
Tuvalu
Vanuatu
Vietnam
Wallis and Futuna
West Samoa

Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.

FIGURE 12-12.2-4 LIST OF OVERSEAS REMOTE, NON-REMOTE, & MTF COUNTRIES BY REGION (CONTINUED)

TRICARE LATIN AMERICA
Arguilla
Antigua
Argentina
Aruba
Bahamas
Barbados
Belize
Bermuda
Bolivia
Brazil
British Virgin Islands
Canada
Cayman Island
Chile
Colombia
Costa Rica
Cuba
Dominica and Dominica Republic
Ecuador
El Salvador
Falkland Island
French Guianea
Grenada
Guadeloupe
Guatemala
Guyana
Haita (includes Navassa Islands)
Honduras
Jamaica
Martinique
Mexico
Montserrat
Netherlands Antiles
Nicaragua
Panama
Paraguay
Peru
Puerto Rico*
St Kitts and Nevis
St Lucia
St Vincent
Surinam
Trinidad and Tobago

Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.

TRICARE LATIN AMERICA
Turks and Caicos Islands
Uruguay
Venezuela, Bolivarian Republic of
Virgin Islands, U.S.

Asterisk (*) denotes countries requiring authorization when claim is submitted by other than the TGRO contractor.

FIGURE 12-12.2-5 LIST OF OVERSEAS REMOTE AREAS BY REGION

TRICARE EUROPE	
Albania	Tirana
Algeria	Algiers
Angola	Luanda
Armenia	Yerevan
Austria	Vienna
Azerbaijan	Baku
Belarus	Minsk
Belgium	Kleine Brogel
Bosnia-Herzegowina	Sarajevo
Botswana	Gaborone
Bulgaria	Sofia
Burundi	Bujumbura
Cameroon	Yaounde
Chad	N'Djamena
Congo, Democratic Republic	Kinshasa
Croatia	Zagreb
Cyprus	Nicosia
Czech Republic	Brno, Prague
Denmark	Copenhagen
Djibouti*	Djibouti
Egypt*	Cairo, Ismail, Maadi, New Maadi
Eritrea*	Asmara
Estonia	Tallinn
Ethiopa*	Addis-Ababa
Finland	Helsinki
France	Istres, Paris
Gabon	Libreville
Georgia	Tbilisi
Germany*	Berlin, Bonn, Bremerhaven, Flensburg, Garmisch-Partenkirchen, Kalkar, Muenster, Munich, Pfullendorf, Ulm
Ghana	Accra
Greece	Athens, Larissa
Republic of Guinea	Conakry

Asterisk (*) denotes countries to be brought on-line 09/01/2003. No asterisk denotes countries to be brought on-line as of 10/01/2003.

TRICARE EUROPE	
Hungary	Budapest
Ireland	Dublin
Israel	Jerusalem, Tel Aviv
Italy	Ghedi, Latina, Milan, Poggio Renatico, Rome, Taranto
Ivory Coast (Cote D' Ivoire)	Abidijan
Jordan*	Amman
Kazakhstan*	Almaty
Kenya*	Nairobi
Kuwait*	Kuwait City (Al-Kuwayt)
Kyrgyzstan*	Bishkek
Latvia	Riga
Lebanon	Beirut
Luxembourg	Luxembourg
Liberia	Monrovia
Lithuania	Vilnius
Macedonia	Skopje
Mali	Bamako
Malta	Valletta
Moldova	Chisinau
Morocco	Rabat
Mozambique	Maputo
Namibia	Windhoek
Netherlands	The Hague, Rotterdam, Volkel
Niger	Niamey
Nigeria	Lagos
Norway	Oslo, Stavanger
Oman*	Madinat Qaboos, Muscat
Pakistan*	Islamabad, Karachi
Poland	Warsaw
Portugal	Lisbon
Qatar*	Doha (Ad-Dawhah)
Romania	Bucharest
Russia Federation	Moscow, St. Petersburg
Rwanda	Kigala

Asterisk (*) denotes countries to be brought on-line 09/01/2003. No asterisk denotes countries to be brought on-line as of 10/01/2003.

TRICARE EUROPE	
Saudi Arabia, Iraq*	Dhahran, Jeddah, Riyadh
Senegal	Dakar
Serbia - Montenegro	Belgrade
Seychelles	Seychelles
Slovakia	Bratislava
Slovenia	Ljubljana
South Africa	Cape Town, Johannesburg, Pretoria
Spain	Madrid, Moron de la Frontera, Valencia
Sweden	Stockholm
Switzerland	Bern, Chambessy
Syria	Damascus
Takjistan	Dushanbe
Tanzania	Dar Es Salaam
Togo	Lome
Tunisia	Tunis
Turkey	Ankara, Istanbul, Izmir
Turkmenistan*	Ashgabat
UAE (United Arab Emirates)*	Abu Dhabi, Dubai
Uganda	Kampala
Ukraine	Kiev
United Kingdom	Cheltenham, Digby, Portsmouth, Yeovilton
Uzbekistan*	Tashkent
Yemen	Sanaa
Zambia	Lusaka
Zimbabwe	Harare

Asterisk (*) denotes countries to be brought on-line 09/01/2003. No asterisk denotes countries to be brought on-line as of 10/01/2003.

FIGURE 12-12.2-5 LIST OF TGRO AREAS BY REGION (CONTINUED)

TRICARE PACIFIC	
American Samoa	Pago Pago, Nuuuli
Australia	Alice Springs, Brisbane, Canberra, Darwin, Edinburgh, Exmouth, Katherine, Melbourne, Newcastle, Nowra, Puckapunyal, Richmond, Sydney, Toowoomba, Townsville,
Bangladesh	Dhaka
Cambodia (Kampuchea)	Phnom Penh
China	Beijing, Hong Kong, Shanghai
Fiji	Nadi, Suva
India	Coimbatore, Haryana, New Delhi
Indonesia	Jakarta
Japan	Central Tokyo, Gotemba, Osaka, Sapporo
Laos	Vientiane
Madagascar	Antananarivo
Malaysia	Kuala Lumpur
Mongolia	Ulaanbaatar
Myanmar (Burma)	Yangon
Nepal	Kaphmanda
New Zealand	Auckland, Christchurch, Wellington
Northern Mariana Islands	Saipan
Philippines	Manila, Quezon City
Palau	Koror
Singapore	
Sri Lanka	Colombo
Taiwan	Taipei

TRICARE PACIFIC	
Thailand	Bangkok, Chiangmai, Nakhon, Ratchasima, Pattaya City, Phuket
Vietnam	Da Nang, Hanoi, Ho Chi Minh City

TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN	
Antigua	English Harbour
Argentina	Buenos Aires
Bahamas	AUTEC, Nassau
Barbados	Bridgetown
Belize	Belize City
Bolivia	La Paz
Brazil	Brasilia, Rio, Sao Pablo, Sarocabo
Chile	Santiago
Colombia	Bogota
Costa Rica	San Jose
Dominica, Dominican Republic	Goodwill Roseau, Santo Domingo
Ecuador	Manta, Quito
El Salvador	San Salvador
Grenada	St George's
Guatemala	Guatemala City
Guyana	Guyana
Haiti	Port Au' Prince
Honduras	Soto Cano, Tegucigalpa
Jamaica	Kingston
Mexico	Chiguagua, Mexico City, Monterey
Netherlands Antilles	Aruba, Williamstad Curacao
Nicaragua	Managua
Panama	Chiriqui, Panama City, Santiago
Paraguay	Asuncion
Peru	Lima
Puerto Rico	Aguadilla, Arecibo, Caguas, Carolina, Fajardo, Humacao, Mayaguez, Ponce, San Juan**
Surinam	Para Maribo
Trinidad & Tobago	Port of Spain
Uruguay	Monte Video
Venezuela	Caracas
U.S. Virgin Islands	

**** Denotes designation effective 05/01/2004.**

FIGURE 12-12.2-6 MTF COUNTRIES

TRICARE EUROPE
United Kingdom
Spain
Belgium
Germany
Italy
Turkey
Iceland
Azores
This does not apply to city/ countries identified as remote (see Figure 12-12.2-5).

TRICARE PACIFIC
South Korea
Japan
Guam
This does not apply to city/ countries identified as remote (see Figure 12-12.2-5).

TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN
Guantanamo Bay, Cuba
This does not apply to city/ countries identified as remote network locations (see Figure 12-12.2-5). **Aeromedical evacuation authorized under TGRO effective 04/01/2004.**

FIGURE 12-12.2-7 TAO DIRECTOR ACTIVE DUTY PROGRAM NON-AUTHORIZED STATESIDE CLAIMS REPORT

	SPONSOR	PATIENT	SPONSOR	PROVIDER		HCDP DMIS			PURPOSE	REASON FOR REFERRAL*	APV.	
ICN	LAST 4 DIGITS SSN	NAME	NAME	NAME AND ADDRESS	DATES	ID CODE	ICD9	CPT[1] CODE	VISIT	A	Y	N
19981733260365 A	123 45 6789	Smith, Ann S.	Smith, John M.	Bauman, Peter 121 Jay Street Aurora, CO 80045	11-01-00- 11-15-00							
19981753245002 A	987 65 4321	Jones, Sally	Jones, Tom M.	Shepherd, Cameran * 425 Cello Drive Arvada, CO 80005	11-02-00- 11-05-00							

* A = Authorization

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FIGURE 12-12.2-8 OVERSEAS PHARMACY PROVIDER NOTICE LETTER (SAMPLE)

(**Insert Provider Name**)
(**Insert Provider Street Address**)
(**Insert Provider City, State and Zip Code**)

Dear (**Insert Provider Name**):

The Department of Defense, through TRICARE Management Activity, is responsible for appropriate cost containment for services provided to TRICARE beneficiaries. One particular area of concern has been the costs billed for prescription drugs. In an effort to establish a Uniformed Military Services drug benefit and claim processing requirement for all TRICARE eligibles, the Executive Director, TMA, has determined that pharmacy claims submitted for services outside the United States must be reimbursed in accordance with the reimbursement formulas for TRICARE United States (U.S.) claims as established under the Code of Federal Regulations.

This letter notifies you that sixty (60) days from the date on this letter, overseas pharmacy claims must comply with TRICARE requirements for a National Drug Coding (NDC). Claims must include correct and complete NDC coding, whether submitted electronically or using standard claim forms. Drug claims received for processing for dates of service on or after (**insert date sixty (60) days from the date on this letter**) that do not have applicable NDC coding will be returned.

Additionally, effective sixty (60) days from date on this letter, (**insert date**), overseas pharmacy claims submitted will be processed in accordance with the reimbursement formulas for TRICARE CONUS claims which is Blue book rates plus $3.00 administration fee. Should you have any questions regarding this requirement, please write me at (**insert contractor mailing address**).

Sincerely,

(**Insert Managed Care Contractor Name**)

(**Insert Managed Care Contractor Title**)

FIGURE 12-12.2-9 INQUIRY FORM (EXAMPLE)

TOP CLAIM INQUIRY

In order that we may answer your claim quickly, please complete the information below and mail to:
TRICARE Managed Care Contractor - *(insert address of managed care contractor)*

Address

Last Name First Middle

City State Zip

Telephone Number is:

(Home) ( ) -

(Duty/Work) ( ) -

Date _____

Check One:
- ❑ A claim has been submitted, but payment or other notification has not been received.
- ❑ Notification or payment concerning a claim has been received, but I feel you may have processed it incorrectly.
- ❑ Deductible status
- ❑ Other (Explain in "J" below)

A. Coverage is under ❑ **PRIME** ❑ **STANDARD** **B.** Sponsor's SSN _____

C. Sponsor's Name _____ **D.** Patient's Name _____

E. Patient's Mailing Address _____

_____ **TELEPHONE NUMBER** _____

F. Name and location of hospital, physician, pharmacist, etc., who provided these services _____

_____ **TELEPHONE NUMBER** _____

G. Date(s) of services on claim _____ **H.** Total Charges _____

I. Claim number that appears on your TRICARE Explanation of Benefits (leave blank if an Explanation of Benefits has not been received) _____

J. Other (Please explain your question in as much detail as possible):

_____
_____
_____
_____

Beneficiary / Provider Signature _____

RESPONSE:

_____
_____
_____
_____

Managed Care Contractor Customer Service _____

FIGURE 12-12.2-10 POC REQUEST DESIGNATION LETTER (EXAMPLE)

LETTER TO TMA FOR OFFICIAL TRICARE POINT OF CONTACT
(If required by the Regional Director Fax the POC request letter
to the TAO Director)

(**Military/Embassy Letterhead**) Date

TO: TRICARE Management Activity
ATTN: COR, (appropriate overseas area)
(**address for TGRO/TPRC correspondence only**)
Skyline Five, Suite 810
5111 Leesburg Pike
Falls Church, VA 22041-3206
- or-
(**address for all other overseas area correspondence**)
16401 East Centretech Parkway
Aurora, CO 80011-9066

SUBJECT: TRICARE Overseas POC (**Initial or Update**)

1. Request approval of the following individuals as official TOP POCs:

Primary: Name, Branch of Service (if applicable)
Commercial phone number
24 hour Commercial Fax number
Email address
Address:

Alternate: Name, Branch of Service (if applicable)
Commercial phone number
24 hour Commercial Fax number
Email address
Address:

2. If updating indicate if the new individuals nominated will be replacing previously designated POCs or if they are additions to previously designated POCs.

3. Include justification if requesting approval for more than three alternate POCs.

4. (**POC name**) is the TOP point of contact for TOP for the U.S. (**Embassy, Defense Attache' Office or Military Group Office, etc.**) in (**country**) until (**timeframe**).

4. Thank you for your assistance in this matter. If there are any problems with this request, please contact (**POC**) at (**phone number**).

(**signature block for Office In Charge (OIC) or Commanding Officer**)

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET

TOP AND TDP PROGRAMS

Point Of Contact Booklet

AUGUST 2005

Office Of The Assistant Secretary Of Defense For Health Affairs

TRICARE MANAGEMENT ACTIVITY

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

TOP AND TDP POINT OF CONTACT PROGRAM

INTRODUCTION

The Point of Contract (POC) Program for TRICARE Overseas Program (TOP) healthcare claims has been in operation since 1991. The POC Program is designed to provide beneficiaries and host nation providers assistance with filing TRICARE claims for care received in foreign countries. This liaison service is designed to ensure timely overseas claim filing and payment. With the expansion of the POC program to include TRICARE Dental Plan (TDP) claims, beginning May 1999, the Department continues to provide another important tool to ensure beneficiary access to quality host nation healthcare. Oversight and support of a designated POC by the various Uniformed Services Branches is critical to assure the continued success of the POC program.

Note: For POCs at TRICARE Global Remote Overseas (TGRO) locations in Europe, Africa, and the Middle East, all care must be coordinated through International SOS (ISOS). For a listing of remote sites and local access numbers, please see:

http:// www.europe.tricare.osd.mil/

and search on "Remote Site Health Care" or call ISOS directly at 44-20-8762-8133 (collect).

BACKGROUND

Military family members in foreign countries have had trouble getting medical and dental care from host nation providers for the following reasons:

- Delays in beneficiary/provider filing of TOP claims;
- Delays in host nation mail service;
- Delays in host nation provider payment by the beneficiary, upon receipt of TOP payment.

To reduce these delays, TRICARE Management Activity (TMA) established a dedicated foreign claims processing department to handle TOP and TDP claims. Each specialized foreign claims processing department has a dedicated staff to process only TOP or TDP claims, dedicated data fax capabilities, and a dedicated post office box for the receipt of TOP or TDP claims and correspondence. TOP/TDP dedicated foreign claims processing departments also have electronic mail capability for receiving TDP correspondence.

Although the volume of TOP and TDP claims is small, the claims receive priority processing. The special handling provided by the dedicated TOP and TDP foreign claims processing departments, combined with the valuable liaison service provided by local designated POCs results in the retention of quality host nation providers to treat the Department's beneficiary population while on overseas assignment.

WHO MAY QUALIFY TO BE A POINT OF CONTACT?

A designated Point of Contact (POC), must be either:

- An Active Duty military member; or
- A civilian employee working for, and under the oversight of, the military/U.S. Government who will be remaining at the same location for a least 12 months.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

POC DESIGNATION

POC designation is usually limited to one Primary POC and one or two alternate POCs. Additional alternate POC's maybe designated when justified by the Commanding Officer upon requesting designation.

Requests for POC designation must be in writing, signed by the POC's Commanding Officer of a foreign base or location, Defense Attache Office (DAO), and Security Assistant Organizations, and must be faxed to (303) 676-3935 (for TMA COR(s)s located in Aurora) or (703) 681-1219 (for TMA COR(s) located in Falls Church) or mailed to the appropriate TMA COR. The request must include the POC's complete mailing addresses, telephone, and fax numbers, and e-mail address when available, name of the POC, name(s) of the alternate POC(s), justification of the additional alternate POC's, and indication whether the change is new, replacing existing designated POC's or adding POC designation.

TMA POC designation is "purple suited" and not Uniformed Service specific, nor is designation limited to a specific category of TRICARE benefit (i.e., medical, drug, maternity) or for a specific category of TOP beneficiary (ADSM, ADFM, retiree, etc.).

Upon approval, TMA will notify the requestor, the contractors, Overseas TAO Director, via e-mail and/or fax.

DUTIES OF THE POINTS OF CONTACT

Designated POCs must:

- Assist all Uniformed Services TRICARE beneficiaries, and active duty members, regardless of Service affiliation, and host nation providers with completion of and filing TOP and TDP claims with the appropriate claims processor.
- Provide ongoing education to beneficiaries/provider on the TRICARE program benefits and correct claims filing.
  - A. NOT submit claims for care not yet received.
  - B. New claims should NOT be faxed on the contractor's inquiry fax number.
- Develop procedures for the coordination, control and tracking of either faxed or mailed claims from within their areas of responsibility to the appropriate claims processing contractors. This process must include the receipt of and distribution of foreign drafts/U.S. dollar checks/explanation of benefits (EOB) received from the contractors as payment for services rendered by host nation providers.
- Establish and maintain a file for the original claim and all related correspondence faxed to the contractor.
- Provide their **commercial**, not DSN or AUTOVON, telephone, and fax numbers address, including e-mail address, if available, on the TOP claim inquiries fax cover sheet with each fax claim submission. Fax numbers must be available 24 hours.
- Notify the appropriate TMA COR immediately when POC, POC address, commercial phone and fax number change via fax or e-mail.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

- Ensure that Faxed claims are correctly completed, signed, by the patient, or by the parent in the case of a minor, or that the beneficiary signature is on file. Attach a copy of the front and back of the family member ID card when the family member is not enrolled in DEERS unless the family member is a newborn, in which case the claims will be processed normally without an enrollment or ID card requirement. All Philippines claims must be signed by the beneficiary/provider. POCs may not use signature on file for Philippines claims.

  NOTE: For active duty member claims, if the active duty member signature is not present on the claim form, the military command must submit a letter of explanation along with the claim prior to the contractor payment.

  NOTE: *For TDP dental claims,* a properly completed "Non-Availability and Referral Form" must accompany the dental claim form, except for non-orthodontic services performed in remote locations. The form must be issued by the enrolled family member's servicing overseas dental treatment facility (ODTF), or the appropriate Overseas TAO Director, or their designee, depending on where the family member lives and the dental services that are performed. The POC *may not* complete this form. The TDP contractor has published a reference guide to assist ODTFs, Overseas TAO Directors and POCs in the management of TDP dental claims. This "Authorization and Referral Manual" documents the proper procedures for the issuance of TDP authorizations, referrals and claims payment processes. This manual takes precedence over any potential conflicting instructions in this publication.

- Attach copies of all related itemized bills (not receipts) with the claim.
- Ensure claims for *adjunctive dental care* are sent to the appropriate TRICARE contractor responsible for processing medical claims and not the TDP contractor.
- Provide the specialized foreign claims processors any additional information that may be required by the contractor(s) to finalize the processing of a claim via fax/email, within 10 calendar days of receipt of the request.
- Shall, when submitting a contractor claims inquiry, refer to the claim number of the claim in question and provide a copy of the TRICARE Explanation of Benefit (TEOB) with the inquiry and/or a copy of the contractor letter that requests additional information. POC's may fax or e-mail inquiries to the claims processing contractor. Each fax inquiry should be accompanied by a completed TOP Inquiry Form that clearly identifies the number of pages in the fax, who to contact about the inquiry, the fax number and phone number.
- Shall allow the overseas claims processing or TDP contractor 21 days to respond to a fax inquiry before requesting claim/fax inquiry status. If after 30 days, the POC is not able to resolve the issue with the claims processing contractor, the POC shall contact the appropriate TOP Overseas TAO Director.
- Shall allow the overseas claims processing or TDP contractor for new claims, 30 days to process/pay and mail the claims back to POC. If the POC has not received a claim payment/denial notice from the contractor within 30 days, the POC should follow the inquiry process outlined in this section.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

- Use priority pouch mail for receipt of foreign drafts/U.S. dollar checks/EOBs from the TRICARE contractors.
- Distribute foreign drafts/U.S. dollar checks/EOBs to appropriate sponsors/beneficiaries or host nation providers immediately upon receipt.
- Report unresolved claims problems or issues between the TRICARE contractor and the POC concerning policies or program requirements for:
  - ➢ TOP issues first to the appropriate Overseas TAO Director for resolution. If the contractor and the Overseas TAO Director are unable to resolve the issues, the TOP issue should be referred to the appropriate TMA COR.
  - ➢ TDP issues to the TRICARE Management Activity, Chief, Special Contract Operations Office, 16401 East Centretech Parkway, Aurora, CO 80011.
- Educate local beneficiaries and host nation providers on the correct procedures for filing their claims.
- Stress the importance of filing claims within 30 days following receipt of TOP or TDP since timely filing ensures prompt payment of care received.
- Submit request for overseas enrollment directly to the appropriate overseas TAO Directors office for assistance.

DUTIES OF THE MANAGED CARE CONTRACTORS

The TOP and TDP dedicated claims processing departments must:

- Assist the TOP and TDP POCs, Uniformed Services, TRICARE beneficiaries, active duty members where appropriate, and host nation providers with information on the completion of and filing of claims with the appropriate claims processor.
- Develop internal procedures for the coordination, control and tracking of faxed or mailed claims from receipt to final processing. This includes, but is not limited to, storage/maintenance of the claim and all related correspondence, microfilming/imaging of claims upon receipt, the issuance of foreign drafts/U.S. dollar checks/EOBs, and development procedures for missing information needed to process the claim to completion.
- Provide a dedicated P.O. box for the receipt of TOP and TDP claims.
- Provide a dedicated fax number for the receipt of POC claims.
- Accept only faxed claims/inquires/information faxed by an officially designated POC or an alternate POC. Electronic mail may also be used for TOP/TDP inquiries/information.
- Verify beneficiary eligibility for TOP or TDP benefits.
  - ➢ For TOP claims, a copy of the front and back of the dependent ID card must be sent in with the TOP claim and may be used as eligibility verification by the managed care contractor when the family member is not enrolled in DEERS.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

- ➢ For TDP claims, the family member must first be enrolled in DEERS and the TDP, and the sponsor must pay the appropriate premium, before services can be rendered and his/her claims processed. The sponsor should verify on his/her Leave and Earnings Statement (LES) that the correct payroll deduction has been taken. The sponsor is also advised to contact the TDP contractor before receiving services to ensure that the proper enrollment information has been received and to confirm the actual coverage date.

- Review claims to ensure the beneficiary/provider has provided complete and accurate information prior to submitting claims for processing/payment.
- Process TOP claims using guidelines in this chapter.
- Process TDP claims per contract requirements and the guidelines outlined in the "Authorization and Referral Manual".
- Be able to translate claims submitted in a foreign language.
- Pay claims using the exchange rate in effect on the last date of service listed on the claim.
- Make payment as follows:
  - ➢ For TOP Claims:
    - Issue foreign currency drafts for TOP claims. Drafts may not be changed to a U.S. dollar check after the managed care contractor has issued a foreign draft.
  - ➢ For TDP Claims:
    - Issue foreign currency drafts for TDP claims submitted by providers via POCs.
    - Issue U.S. dollar checks for TDP claims submitted by a sponsor/family member, via POCs. Payment may not be changed to local currency after the U.S. dollar check has been issued.
  - ➢ For TOP and TDP Claims:
    - Issue foreign currency drafts for both TOP and TDP claims when the sponsor/family member requests payment in local foreign currency only at the time the claim is submitted.

      NOTE: Foreign drafts are good for 190 days and may be cashed at any time. U.S. dollar checks are good for a limited period of time and must be reissued by the TRICARE contractors upon expiration of the check before the check can be cashed.

- Use priority pouch mail for the mailing of foreign drafts/U.S. dollar checks/EOBs to appropriate sponsors/beneficiaries and/or host nation providers for claims submitted via POCs. The priority pouch mail must be sent using the fastest means available to the POC's location.
- Report unresolved claims problems or issues between the Overseas TAO Director and the managed care contractor concerning policies or program requirements for:
  - ➢ TOP issues to the appropriate TMA COR.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

- ➢ TDP issues to the TMA, Chief, Special Contract Operations Office, 16401 East Centretech Parkway, Aurora, CO 80011.

HELPFUL HINTS

- Make sure the TOP and TDP claim form is completed and signed by the patient or by the parent (or responsible party) in the case of a minor.
- Do not send TOP or TDP claims provided to two different beneficiaries by the same provider on the same claim form. Each beneficiary should file claims on a separate form.
- Remember the TOP claims department processes only healthcare and adjunctive dental claims for services provided in foreign countries and TOP Prime/Standard healthcare provided in the U.S.
- Remember the TDP claims department processes all TDP claims for enrolled family members, regardless of where the service was performed.
- Remember to remind beneficiaries and providers that the TOP and TDP programs do not share the cost of all types of healthcare or dental care. Therefore, TRICARE payment for every service received can't be guaranteed.
- Remember to use the beneficiary's claim number listed on the EOB when making specific claims inquiries to the TOP and TDP contractors.
- Remember to state on the claim form who payment should be made to: Beneficiary or Provider.

  NOTE: Do not send a new claim when the first claim has been denied or was processed incorrectly. Contact the appropriate TRICARE contractor for assistance.

SUMMARY

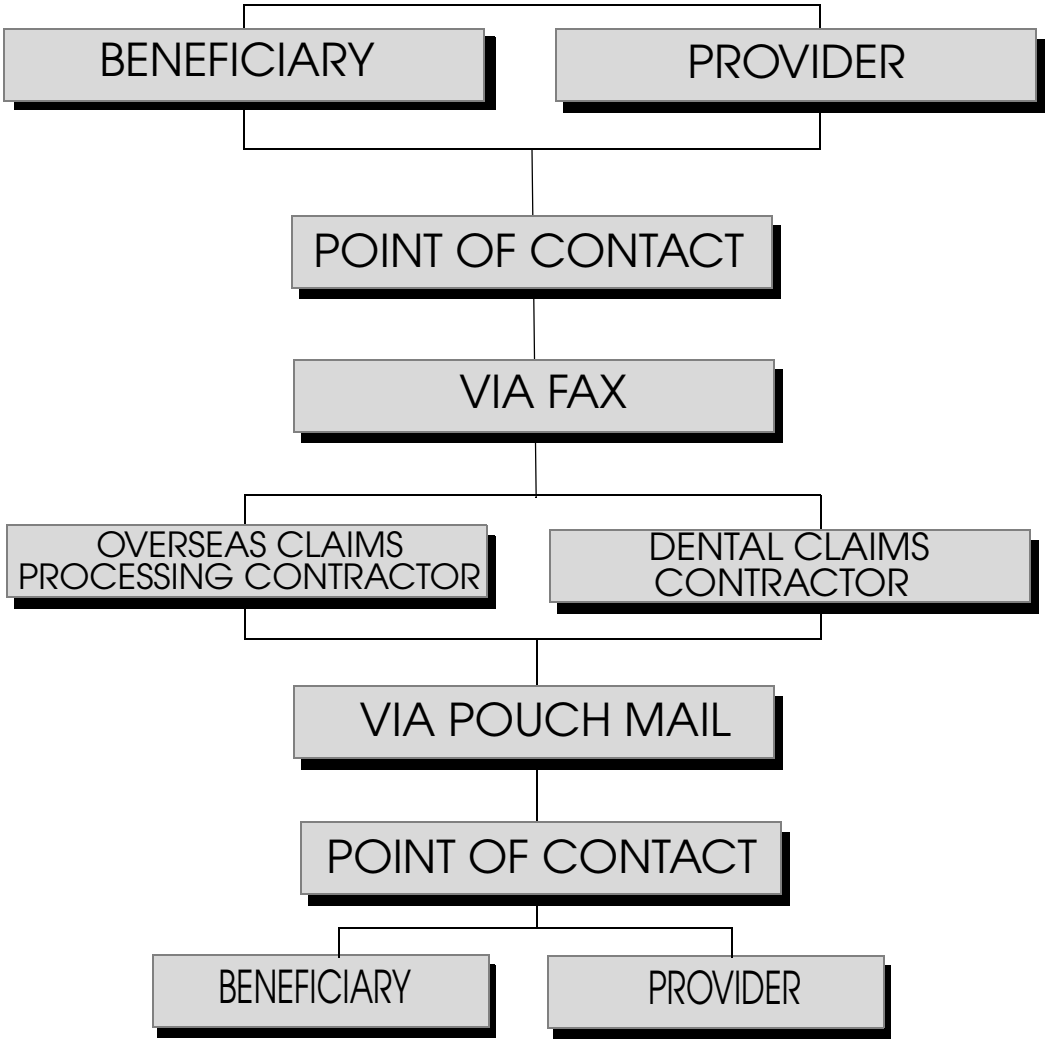
The TRICARE contractors' foreign healthcare and dental claims processing departments can only be effective if the Services designate POCs and the designated POCs understand the TOP and TDP programs and the claims processing requirements. The POC must also communicate with the TRICARE contractors' foreign healthcare and dental claims departments on a regular basis.

Although the POC program is not required for all locations and situations, the use of the POC concept does improve the situation for accessing and ensuring prompt payment to host nation providers in countries that take full advantage of the system.

The attached flowchart summarizes the recommended foreign claims submission process.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

RECOMMENDED FOREIGN CLAIMS METHOD



TOP CLAIM FORMS

TOP claims should be filed on the DD 2642. Copies of each of the claim form is attached. Copies of these claim forms may be found and downloaded on the TMA website at http://www.tricare.osd.mil.

Directions for completing the claim form are included on the back of the form. If you need help in filling out the claim form or have questions, please contact either the Overseas TAO Director for your area.

NOTE: If the above form are not available, the TOP managed care contractor may accept any authorized TRICARE claim form current/obsolete.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

- 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 ☐ OTHER *(Specify)*
☐ NATURAL OR ADOPTED CHILD

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?
☐ OUTPATIENT?
☐ DAY SURGERY?

9. SPONSOR'S NAME *(Last, First, Middle Initial)*

10. SPONSOR'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 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
☐ (2) PRIVATE *(Non Group)* ☐ (4) STUDENT PLAN ☐ (6) OTHER *(Specify)*

	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE *(Street, City, State, and ZIP Code)*	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE *(YYYYMMDD)*
INSURANCE 1			
INSURANCE 2			

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

HOW TO FILL OUT THE 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., former spouse.
5. Enter patient's date of birth (month/day/year).
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 CHAMPUS." The form may be obtained from the claims processor, Health Benefits Advisor 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 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 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 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 CHAMPUS supplemental plans must pay before 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 the CHAMPUS claim. *The CHAMPUS 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.

DD FORM 2642 (BACK), NOV 1999 COPY 1 - PATIENT'S COPY

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

- PATIENT'S COPY -

CHAMPUS CLAIM PATIENT'S REQUEST FOR MEDICAL PAYMENT	*Form Approved* *OMB No. 0720-0006* *Expires Sep 30, 2002*

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0006), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS. RETURN COMPLETED FORM TO THE APPROPRIATE CHAMPUS CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A HEALTH BENEFITS ADVISOR 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. 613; 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 Transportation 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 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) or Uniformed Services Treatment Facility (USTF) (generally within a 40-mile radius of the MTF or USTF), the patient must obtain a Nonavailability Statement for most inpatient care that is not a bona fide emergency. A Nonavailability Statement is also required for some outpatient procedures. *Contact your Health Benefits Advisor for more information. The claims processor will deny your claim if you need a nonavailability statement authorization and do not have one.*

* * * * * *

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: All prescriptions require the name of the patient; the name, strength, and quantity of each drug; 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.

* * * * * *

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. Contact a CHAMPUS Health Benefits Advisor or TRICARE Management Activity if you need the name and address of your claims processor. If a claim is returned for additional information, it must be resubmitted by the filing deadline, 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 Health Benefits Advisor at the nearest military treatment facility or TRICARE Management Activity, 16401 E. Centretech Pkwy., Aurora, CO 80011-9043.

*** * *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 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 CHAMPUS" 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.

DD FORM 2642, NOV 1999 PREVIOUS EDITION IS OBSOLETE. **COPY 1 - PATIENT'S COPY**

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

SAMPLE

ATTENDING DENTIST'S STATEMENT

Check One: ☐ Dentist's pre-treatment estimate
☑ Dentist's statement of actual services

1. Patient name: Jane J Doe
2. Relationship to sponsor: spouse X
3. Sex: F X
4. Patient birthdate: 10 27 57
5. If full time student, school: Education University, Frankfurt
6. Sponsor's name: James T. Doe
7. Sponsor's social security no: 999-99-9999
8. Patient's mailing address: Box 1267, APO AE 01234 (Germany)
9. Branch of service: Army
11. Group name: TRICARE Family Member Dental Plan
12. Is patient covered by another dental plan? ☐ yes ☑ no — Dental plan name: Dental Insurance Company
Insurance coverage no.: 111-11-1111 — Group no: 000123450
Name and address of carrier: Dental Insurance Company, 1415 Main Street, Chicago, IL
Patient or parent/guardian must sign here: HE/SHE WANTS PAYMENT TO GO TO DENTIST 1/5/99
Signature (insured member) — Date
8A. Dentist's telephone number: (011)0711-638472
8B. Evening telephone number: (011)0711-527361
I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
Patient or parent/guardian sign here: 1/5/99
Signature (patient or parent if minor) — Date
13. Dentist's name: Dr. Franz Schmidt
14. Mailing address: Kabingstrase 30, 54270 Fürth (Germany)
15. Dentist's telephone: (011)1487-639-465
17. Date first dental treatment began: 1/5/99
18. Place of treatment: Office X, Home, ER, Other
19. Radiographs and other supporting documentation enclosed? ✓
20. Is treatment for orthodontics? ✓
21. Is treatment result of occupational illness or injury? ✓ No
22. Is treatment result of auto accident? ✓ No
23. Other accident? ✓ No
23. Are any services covered by another plan? ✓ No
24. Is prosthesis or prior dental placement? ✓ No
If no, reason for replacement
26. Date of prior placement
Total length of treatment

27. Examination and treatment plan (a) in order from Tooth No. 1 through Tooth No. 32. Use blending system shown.

Tooth No. or Letter	Surface	Description of Procedures (including drugs, prosthetic materials, specific)	Date Performed (Month Day Year)	Procedure Code	Fee Charged	Amount Paid
		(b) Examination	(c) 1 5 99		(e)	
(a) 12		(b) Filling on one surface	(c) 1 5 99		(d)	

Note: If the claim form is used as the dentist's bill, then include the following information as shown above (a) tooth number (b) description of services provided (c) date of service (d) fee charged (If individual fee/service charge is known, please enter. If not known, enter total fee charged)

28. Attachments for unusual services

Note: If services are listed on the dentist's bill attach the bill to this claim. You do not need to complete this section.

Any person who knowingly makes a false statement or claim containing any material misrepresentation of any fact, incorrect, misleading information or conceals facts for purpose of misleading information concerning any fact material thereto may be guilty of a criminal offense under state and/or federal law and may also be subject to civil penalties. I hereby certify that the procedures indicated by date have been performed.
Dentist must sign here unless bill is attached. End dentist's name is listed on the bill.
Signature — Date: Complete unless date is on the attached bill

TOTAL FEE CHARGES (d) 50 DM — AMOUNT PAID

DD FORM 2569 OCONUS

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

TDP CLAIM FORM

There are numerous claim forms used to process dental claims. To expedite processing, the Government will utilize the existing stateside U.S. (CONUS) TDP claim form. The following suggestions for filling out the dental claim form will help to minimize problems and reduce delays in claims processing by the managed care contractor. A copy of the dental claim form and a sample of a completed form are also provided.

FILLING OUT A TDP DENTAL CLAIM FORM

Most of the blocks on the dental claim form are self-explanatory (see completed example below). But, there are certain blocks to which special attention should be paid as noted below:

Block above Block 1--If the provider or sponsor/family member wishes to obtain a pre-treatment estimate (or predetermination) of the services they would like performed, they should check the box marked "Dentist's pre-treatment estimate". When a pre-treatment estimate is checked, no dates of service should be listed in Block 27, Examination and Treatment Plan. If the provider or sponsor/family member wishes to submit a claim for the actual services rendered, they should check the box above block 1 marked "Dentist's statement of actual services".

Upper left corner ("Attending Dentist's Statement"): Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.

Block 1--Only one patient per claim form. But you may attach more than one bill for the same patient. Be sure to use the name as it appears on the patient's ID card--or, for young children, as entered in DEERS.

Block 4--Be sure to enter the patient's birth date here.

Block 5--Indicate if family member is a full time student and, if so, where.

Block 6--The sponsor's nine-digit Social Security Number (SSN) **must** appear on every family member's claim form.

Block 7--Be sure the **Uniformed Services sponsor's** Social Security number is entered.

Block 8--Enter the complete home address of the family member seeking treatment. Indicate APO/FPO or street, city, country and appropriate postal mailing code.

- Be sure to provide the current and complete mailing address to include APO/FPO and/or street, city, country and postal mailing code.

Block 9--Put the sponsor/family member's complete daytime and evening phone numbers in this block so that these parties can be contacted if there is a problem with the claim. Include country and city codes as appropriate.

- Enter the patient's daytime and evening telephone number including applicable city and country codes.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

Signature block immediately under Block 9--This block must be signed and dated by the patient (18 years of age or older) or the parent/guardian if the patient is a minor. Be sure to read the instructions in the TDP Dental Benefit Booklet if someone other than the patient is signing on behalf of the patient.

- Must be signed by the patient, parent or guardian. If the family member is under 18 years old, the parent or guardian must sign the form.

Block 12--If the sponsor/family member has any **other dental insurance** at all, such as a spouse's plan through an employer, check "yes". Give the name and address of the other dental insurance carrier, the insured's social security number, and the other insurance carrier's group number in the space provided. If the sponsor/family member has no other dental plan besides the TDP, check the "no" box.

- Check "No" if the family member has no other dental insurance. If the family member has additional dental insurance, please check "Yes" and include the plan name, SSN, group number, and address of the other carrier.

Signature block immediately under Block 12--This block must be signed and dated by the patient (18 years of age or older) or the parent/guardian if the patient is a minor, if either party wants the provider to receive payment directly ("assignment"). Be sure to read the instructions in the TDP Dental Benefit Booklet if someone other than the patient is signing on behalf of the patient.

- Sign **if** the family member, parent, or guardian wants to assign payment of benefits to the dentist. This means that the TDP contractor will send payment directly to the dentist.

Block 13--This should be the provider's complete name.

Block 14--This should be the provider's complete mailing address, to include street, city, country and appropriate postal mailing code.

- Enter the dentist's complete mailing address to include street, city, country and postal mailing code.

Block 15--This should be the provider's complete commercial phone number, to include country and city codes.

- Provide the dentist's telephone number including all applicable city and country codes.

Block 16--Provide the dentist's Managed care contractor identification number, if known.

Blocks 17, 18 & 19--Complete based on information available from the provider, beneficiary and/or other information on itemized provider bill.

Blocks 20, 21 and 22--If the problem for which the family member went to the provider is work related or accident related (i.e., occupational illness/injury, auto accident, other injury), check the corresponding "yes" in Blocks 20, 21 or 22. If "yes", please provide a brief description and the date(s) of the incident. The managed care contractor will follow up with some questions to make sure that worker's compensation or other insurance helps pay the bills.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

Blocks 24 and 25--Answer only if the service is for a prosthetic device. Check with the provider for this information.

Block 26--Indicate "yes" if treatment is for orthodontics. If "yes", insert the date the orthodontic appliance was inserted and the expected length of the overall orthodontic treatment plan. Check with the sponsor/family member or provider for this information.

Block 27--From the provider's itemized bill or other available information, provide as much detail to indicate the service(s) that was ordered, performed or prescribed, the specific tooth/teeth treated, and the date(s) of service. Match services with specific tooth numbers to the greatest extent possible. For each service listed, provide the condition for which the patient received treatment and/or the procedure that was performed (attach additional pages as necessary), and the provider's fee that is being charged for each service.

- Provide a detailed description of the services performed including applicable tooth number(s), the date of service, and the fee charged. If services and fees are listed on the dentist's bill, attach the bill to this claim form. In this case, you do not need to duplicate the information in this section.

Signature block immediately under Block 27--This block must be signed and dated by the provider.

- Bottom left corner--The dentist must sign and date here **if** this claim form is used solely as the dentist's bill. If a bill is submitted with the claim form, and the bill clearly identifies the dentist, the dentist's signature is not required.

NOTE: A "Non-Availability and Referral Form" must accompany the claim form and provider's itemized bill for all dental care from non-remote countries and for orthodontic care from remote countries (see the Overseas TDP Authorization and Referral Manual for further information). This form is issued by the family member's servicing ODTF or the appropriate Overseas TAO Director or designee, depending on where the family member lives and the services that are performed.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET (CONTINUED)

General Instructions

- Submit a separate claim form for each family member who receives treatment.
- All claim forms should be submitted to the overseas claims processing or TDP contractor as soon as possible after the service date, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.
- The family member must sign the appropriate sections of the claim form. If the family member is under 18 years old, the parent or guardian must sign the form.
- If you receive care in a non-remote country, submit a completed copy of this claim form along with a valid Non-Availability and Referral Form and the provider's bill to the address on the front of this form.
- For orthodontic care in remote countries, submit a completed copy of this claim form along with a valid Nonavailability and Referral Form and the provider's bill to the address on the front of this form. For nonorthodontic care, only the completed claim form and the provider's bill is required.

Remember

You must submit the following information:

1) A completed claim form.
2) The dentist's bill (if the claim form is not used solely as the bill).
3) A Non-Availability and Referral Form (except for non-orthodontic care in remote locations).

If all necessary information is not included, your claim will be denied.

FIGURE 12-12.2-12 TRICARE GLOBAL REMOTE OVERSEAS (TGRO) HEALTHCARE CONTRACTOR PROVIDER CERTIFICATION REQUEST LETTER

TRICARE
Overseas

(Sample TGRO Philippine Contractor Provider Certification Request Letter)

Dear Provider:

(**Insert Overseas Claims Processing Contractor Name**), your TRICARE claims processor has received a claim for services provided by you.

You are not currently listed with us as a TRICARE authorized/credentialed provider. To complete processing of your claim, you must request to be an authorized/credentialed TRICARE provider. So that we may complete the processing of your claim, please complete the attached TRLICARE Provider Application including copies of your current license(s). Unless we receive the requested license(s)/credentials the claim will be denied.

Please return the completed application with copies of your license(s)/credentials to:

(**Insert TGRO Contractor's Name and Address**)

Sincerely,

(**Insert TGRO Contractor's Name**)

FIGURE 12-12.2-13 TRICARE GLOBAL REMOTE OVERSEAS (TGRO) CONTRACTOR AND/OR TPRC HEALTHCARE CONTRACT TRICARE PROVIDER APPLICATION

(Sample TGRO Contractor and TPRC Remote OverseasProvider Application)

TRICARE PROVIDER APPLICATION

1) Check one that applies:

☐ Physician ☐ Non Physician ☐ Institutional

2) Name _____ Telephone # _____

Medical Speciality_____ Fax # _____

3) Are you in a: (please check one)

☐ Group Practice ☐ Solo Practice ☐ Both

4) Office Location (Street Address):

_____
_____
_____
_____

Office Mailing Address (if different):

_____
_____
_____
_____

5) Group Location (Street Address):

_____
_____
_____
_____

Office Mailing Address (if different):

_____
_____
_____
_____

6) Please Provide:

Medical License # _____
Date Issued _____
Date Expired _____
Issuing Country _____

Business License # _____
Date Issued _____
Date Expired _____
Issuing Country _____

7) Please attach to this form, copies of:

- Current Medical Licenses
- Current Business Licenses

8) Provide Signature _____ Date of Application _____

FIGURE 12-12.2-14 TGRO DMIS-ID BY REGION

TRICARE EUROPE		
DMIS -ID	COUNTRY	FACILITY CITY
6720	Austria	Vienna
6720	Belgium	Klein-Brogel
6720	Denmark	Copenhagen
6720	France	Istress
6720	France	Paris
6720	Germany	Berlin
6720	Germany	Bonn
6720	Germany	Bremerhaven
6720	Germany	Flensburg
6720	Germany	Garmisch-Partenkirchen
6720	Germany	Kalkar
6720	Germany	Muenster
6720	Germany	Munich
6720	Germany	Pfullendorf
6720	Germany	Ulm
6720	Ireland	Dublin
6720	Italy	Ghedi
6720	Italy	Latina
6720	Italy	Milan
6720	Italy	Poggio Renatico
6720	Italy	Rome
6720	Italy	Solbiate
6720	Italy	Taranto
6720	Luxembourg	Luxembourg
6720	Malta	Valletta
6720	Norway	Oslo
6720	Norway	Stavanger
6720	Portugal	Lisbon
6720	Spain	Madrid
6720	Spain	Moron
6720	Spain	Valencia
6720	Sweden	Stockholm
6720	Switzerland	Bern
6720	Switzerland	Chambessy
6720	Switzerland	Geneva
6720	Netherlands	Rotterdam
6720	Netherlands	The Hague
6720	Netherlands	Vokel
6720	United Kingdom	Cheltenham
6720	United Kingdom	Digby
6720	United Kingdom	Portsmouth
6720	United Kingdom	Yeovilton
6721	Albania	Tirana
6721	Armenia	Yerevan
6721	Azerbaijan	Baku

TRICARE EUROPE		
DMIS -ID	COUNTRY	FACILITY CITY
6721	Belarus	Minsk
6721	Bosnia	Sarajevo
6721	Bulgaria	Sofia
6721	Croatia	Zagreb
6721	Cyprus	Nicosia
6721	Czech Republic	Brno
6721	Czech Replublic	Prague
6721	Estonia	Tallinn
6721	Finland	Helsinki
6721	Georgia	Tbilisi
6721	Greece	Athens
6721	Greece	Larissa
6721	Hungary	Budapest
6721	Israel	Jerusalem
6721	Israel	Tel Aviv
6721	Latvia	Riga
6721	Lithuania	Vilnius
6721	Macedonia	Skopje
6721	Moldova	Chisinau
6721	Poland	Warsaw
6721	Romania	Bucharest
6721	Russia	Moscow
6721	Russia	St Petersburg
6721	Russia	Vladivostok
6721	Serbia-Montenegro	Belgrade
6721	Slovakia	Bratislava
6721	Slovenia	Ljubljana
6721	Turkey	Ankara
6721	Turkey	Istanbul
6721	Turkey	Izmir
6721	Ukraine	Kiev
6722	Algieria	Algiers
6722	Chad	N'Djamena
6722	Ivory Coast	Abidijan
6722	Ghana	Accra
6722	Guinea	Conakry
6722	Liberia	Monrovia
6722	Mali	Bamako
6722	Morocco	Rabat
6722	Nigeria	Lagos
6722	Niger	Niamey
6722	Senegal	Dakar
6722	Togo	Lome'
6722	Tunisia	Tunis
6723	Angola	Luanda
6723	Botswana	Gaborone

FIGURE 12-12.2-14 TGRO DMIS-ID BY REGION (CONTINUED)

TRICARE EUROPE		
DMIS-ID	COUNTRY	FACILITY CITY
6723	Burundi	Bujumbura
6723	Cameroon	Yaounde
6723	Congo	Kinshasa
6723	Gabon	Libreville
6723	Mozambique	Maputo
6723	Namibia	Windhoek
6723	Rwanda	Kigali
6723	South Africa	Cape Town
6723	South Africa	Johannesburg
6723	South Africa	Pretoria
6723	Tanzania	Dar Es Salaam
6723	Uganda	Kampala
6723	Zambia	Lusaka
6723	Zimbabwe	Harare
6724	Djibouti	Djibouti
6724	Egypt	Cairo
6724	Egypt	Ismail
6724	Egypt	Maadi
6724	Egypt	Namru
6724	Egypt	New Maadi
6724	Eritrea	Asmara
6724	Ethiopia	Addis Adaba
6724	Jordan	Amman
6724	Kazakhstan	Almaty
6724	Kenya	Nairobi
6724	Kuwait	Kuwait City (Al Kuwayt)
6724	Kyrgyzstan	Bishkek
6724	Lebanon	Beirut
6724	Oman	Muscat
6724	Pakistan	Islamabad
6724	Pakistan	Karachi
6724	Qatar	Doha
6724	Saudi Arabia	Dhahran
6724	Saudi Arabia	Al Kharj
6724	Saudi Arabia	Hofuf
6724	Saudi Arabia	Jubail
6724	Saudi Arabia	Khamis
6724	Saudi Arabia	Tabuk
6724	Saudi Arabia	Taif
6724	Saudi Arabia	Jeddah
6724	Saudi Arabia	Riyadh
6724	Syria	Damascus
6724	Tajikistan	Dushanbe
6724	Turkmenistan	Ashgabat
6724	United Arab Emirates	Abu Dhabi

TRICARE EUROPE		
DMIS-ID	COUNTRY	FACILITY CITY
6724	United Arab Emirates	Dubai
6724	Uzbekistan	Tashkent
6724	Yemen	Sanaa
6724	Seychelles	Victoria

FIGURE 12-12.2-14 TGRO DMIS-ID BY REGION (CONTINUED)

TRICARE PACIFIC	
DMIS-ID	COUNTRY
0983	American Samoa
0983	Australia
0983	Bangladesh
0983	Burma/Myanmar
0983	Cambodia
0983	China
0983	Figi
0983	India
0983	Indonesia
0983	Laos
0983	Madagascar
0983	Malaysia
0983	Mongolia
0983	Nepal
0983	New Zealand
0983	Northern Mariana Islands
0983	Palau
0983	Philippines
0983	Singapore
0983	Sri Lanka
0983	Taiwan
0983	Thailand
0983	Vietnam

TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN	
DMIS-ID	COUNTRY
0970	Antigua
0972	Argentina
0970	Aruba
0970	Bahamas AUTEC
0970	Bahamas
0970	Barbados
0971	Belize
0972	Bolivia
0972	Brazil
0972	Chile
0972	Colombia
0971	Costa Rica
0971	Costa Rica
0972	Colombia
0970	Dominica
0970	Dominican Republic
0972	Ecuador
0971	El Salvador
0971	Guatemala
0972	Guyana
0970	Haiti
0971	Honduras
0971	Honduras Embassy
0970	Jamaica
0971	Mexico
0970	Netherlands Antilles
0971	Nicaragua
0971	Panama
0972	Paraguay
0972	Peru
0972	Suriname
0970	Trinidad & Tobago
0972	Uruguay
0975	U.S. Virgin Islands
0972	Venezuela

FIGURE 12-12.2-15 REMOTE NON-TGRO SITE DMIS-IDS

TRICARE EUROPE		
DMIS-ID	COUNTRY	FACILITY CITY
6897	Afghanistan	
6897	Greece	Araxos
6897	Belgium	
6897	Germany	Buechel
6897	Czech Republic	
6897	Denmark	
6897	Turkey	Eskishir
6897	Italy	Florence
6897	France	
6897	Germany	Freiburg
6897	Germany	
6897	Belgium	Glons
6897	Spain	Granada
6897	United Kingdom	Guernsey
6897	Germany	Hamburg
6897	Hungary	
6897	Iran	
6897	Iraq	
6897	Ireland	
6897	Italy	
6897	Denmark	Karup Denmark
6897	Kenya	Kisumu
6897	Greenland	Nwk
6897	United Kingdom	Oakhanger
6897	Poland	
6897	Kosovo	Belgrade (Pristina)
6897	United Kingdom	RAF Fylingdales
6897	Romania	
6897	Saudi Arabia	
6897	Scotland	
6897	Somalia	
6897	Spain	
6897	United Kingdom	St Helena
6897	Sudan	
6897	Sweden	
6897	Netherlands	Vriezenveen
6897	Libya	Tripoli
6897	Turkey	
6897	United Kingdom	Westisup
6897	Russia	Yekaterinburg
6897	United Kingdom	Gibraltar
6897	Pakistan	Peshawar

TRICARE PACIFIC	
DMIS-ID	COUNTRY
0961	Japan
6898	Other Pacific Non-TGRO (serving Diego Garcia, Kwajalein, Jonston Island)

TRICARE LATIN AMERICA/CANADA	
DMIS-ID	COUNTRY
0969	Canada
0953	Remote Puerto Rico

FIGURE 12-12.2-16 TGRO HEALTHCARE CONTRACTOR CLAIM FORM

(When submitting paper claims.)

TRICARE GLOBAL REMOTE OVERSEAS (TGRO) CONTRACTOR CLAIM FORM

(TGRO CONTRACTOR NAME)
(ADDRESS)
(CITY, STATE ZIP)
(TELEPHONE NUMBER) (FAX NUMBER)

Instructions for Reimbursement of Medical Expenses:

1. The service provider is to complete each section of this claim form after consultation/treatment has been provided and sign.
2. **This claim form must be completed & signed by the patient & the service provider; otherwise it will be declined.**
3. Please send the completed claim form and supporting documents to (**TGRO Contractor Name**).

1) PATIENT INFORMATION

1. Name: _____ 2. Date of Birth: _____/_____/_____
   Last First Middle Initial Mon Day Year
3. Sponsor Name: _____ Sponsor Social Security Number: _____-____-_____
   Last First Middle Initial
4. Relationship to Sponsor: ❑ Self ❑ Spouse ❑ Child
5. Sponsor Status: ❑ Permanently Stationed ❑ Deployed ❑ TDY/TAD (Temporary duty) ❑ Leave
6. E-mail Address: _____ Telephone Contact: _____
7. Permanent Duty Station Address (APO/FPO if applicable):
   _____

2) PATIENT'S CONDITION AND SERVICE PROVIDED:

Diagnosis of the illness/injury

Date of Service	Description of Service (treatment/procedure)	Diagnosis	Unit	Medical Charge (state currency)	*For Official Use Only:*		
					Costs USD	CPT/Rev	ICD-9
	List Medication Prescribed *Over the counter drugs are NOT covered*						
				Total:	Provider Code		

SERVICE PROVIDER INFORMATION (Name, address and telephone)

_____ _____
Signature of Treating Doctor Date

_____ _____
Signature of Patient or Legal Representative Date

FIGURE 12-12.2-17 ATTESTATION

ATTESTATION

I _____ certify that I personally provided the services listed on the attached TRICARE claim I signed and dated

_____(Date Signed)_____ to _____(Patient's Name)_____, a TRICARE Beneficiary. I further certify that the amount billed for these services is the amount I routinely charge the general public, Governmental, and other health plans and health insurers for these services.

I understand that TRICARE beneficiaries are required, by law, to pay their cost-share and deductible and that I will collect the required cost-share and deductible from the beneficiary listed on the claim or another individual or entity on behalf of the beneficiary. I further understand that by accepting the TRICARE payment, I am accepting the TRICARE determined allowable charge plus the beneficiary's cost-share and deductible as payment in full and that I will not bill or collect any amounts in excess of the TRICARE allowable charge. This does not prohibit me from billing for any non-covered services.

_____ _____

Provider's Signature Date

- END -