



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

PRD

CHANGE 52
6010.51-M
JULY 17, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: REVISED PAPER CLAIMS FORMS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Changes to the TSM, TPM, TOM, & TRM in
accordance with the MCSC contracts (paragraph C-7.21.3) and the TDEFIC contract
(paragraph C-3.1). TRICARE requires that contractors and their claims processors
accept and process the nationally recognized paper claims forms and their
successors.

EFFECTIVE AND IMPLEMENTATION DATE: August 31, 2007.

This change is made in conjunction with Aug 2002 TPM, Change No. 60, Aug 2002
TRM, Change No. 63, and Aug 2002 TSM, Change No. 47.

Evie Lammle
Director, Program Requirements Division

ATTACHMENT(S): 12 PAGES
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CHANGE 52
6010.51-M
July 17, 2007

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 7

Addendum C, pages 1 and 2

Addendum C, pages 1 and 2

CHAPTER 8

Section 1, page 3

Section 1, page 3

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Section 3, pages 1 and 2

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Section 4, pages 3 through 7

CHAPTER 20

Section 20, pages 3 and 4

Section 20, pages 3 and 4

HOSPITAL ADJUSTMENTS

This review of hospital-requested claim adjustments assures that the correct diagnosis and procedure information is provided on the adjusted claim form. Thus, the correct DRG can be determined and the adjustment difference can be paid by the contractor.

A hospital may file an adjusted claim within the time period established by the contractor. A change in the principal diagnosis or the sequencing of the diagnoses or procedures may result in a change to a DRG with a higher weight providing for a higher reimbursement rate. Such cases should be closely reviewed before the hospital sends the cases to the contractor for adjusted payment.

When a hospital wishes to submit an adjusted claim, the hospital must send the case directly to the contractor to be reviewed within 60 days of the date of the initial remittance advice. The hospital must provide all of the following information within the 60-day time frame:

- A copy of the initial remittance advice;
- A copy of both the original and updated attestation OR
- A copy of the original attestation which has been corrected and corrections initialed and dated by the attending physician;
- The codes submitted for adjustment;
- An explanation of why the original codes were submitted incorrectly;
- A copy of the original claim form (*CMS 1450 UB-04*);
- A copy of the adjusted claim form;
- A copy of the medical record as required for performing admission review and DRG validation;
- If coding changes are based on newly acquired clinical information, a copy of such information (e.g. autopsy report).

The contractor shall check the date on the remittance advice to determine if the request for adjustment is made within 60 calendar days from the date of the remittance advice. If the 60 day period has expired, the contractor shall deny the claim adjustment and return it to the hospital with a letter explaining the reason for the denial.

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 7, ADDENDUM C

HOSPITAL ADJUSTMENTS

NOTE: If all required documents are not provided, the case shall be returned to the hospital as incomplete. If the required documents are returned to the contractor within the 60-day time frame, the case shall be reviewed. If returned after the 60-day time frame, the case will not be reviewed.

If the hospital submits a request for a higher weight DRG on a case that has previously been scheduled for retrospective review, the case shall be returned to the hospital without review. DRG validation is performed during routine review procedures.

If the 60-day period has not expired and all of the required information has been submitted, the contractor shall use the adjusted codes to regroup the case to determine if it regroups to a higher weight DRG. Only adjusted claims that result in a higher weight DRG will be reviewed. If the case does not regroup to a higher weight DRG, the case shall be returned to the hospital without review. If the case does regroup to a higher weight DRG, all required reviews shall be performed. When potential denial or a coding change other than that requested occurs, appropriate notice letters shall be issued.

The adjusted claim shall be stamped as "APPROVED" or "DENIED" for DRG validation and returned to the hospital along with a letter stating the review results. The hospital then submits an "APPROVED" adjusted claim to the contractor and the "APPROVED" decision stamp flags the claim for adjusted payment. Adjusted claims cases resulting in higher weight DRGs are not eligible for re-review.

The Request for Higher Weight DRG Review form has been developed for use by hospitals in requesting review of higher weight DRG claim adjustments. This form must be completed and submitted with all requests. This form has been developed to assist hospitals in assuring that all required documents are sent with the request for review. Such requests may only be submitted by hospitals. Vendors or consultants may not request higher weight DRG reviews. Any record submitted by these individuals will be returned to the hospital. ALL REQUESTS FOR HIGHER WEIGHT DRG REVIEW MUST BE RECEIVED WITHIN 60 DAYS FROM THE DATE OF THE INITIAL REMITTANCE ADVICE.

TRICARE benefits: the DD Form 2642, the *CMS 1500 (08/05)*, and the *CMS 1450 UB-04*. The American Dental Association (ADA) claim forms may be used in the processing and payment of adjunctive dental claims.

3.2.1. DD Form 2642, "Patient's Request For Medical Payment" (Figure 8-A-1)

This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. Those include physicians, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Extended Care Health Option (ECHO) providers, or other authorized providers. If a DD Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the *CMS 1500 (08/05)* or the *CMS 1450 UB-04*, whichever is appropriate. The new form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the TMA Administrative Office to order the DD Form 2642.

4.0. CLAIMS RECEIPT AND CONTROL

All claims shall be controlled and retrievable. The face of each hardcopy TRICARE claim shall be stamped with an individual *Internal Control Number (ICN)*, which will be entered into the automated system within five workdays of actual receipt. For both hardcopy and EMC, the ICN shall contain the Julian date indicating the actual date of receipt. The Julian date of receipt shall remain the same even if additional ICNs are required to process the claim. If a claim is returned, the date of the receipt of the resubmission shall be entered as the new date of receipt. All claims not processed to completion and supporting documentation shall be retrievable by beneficiary name, sponsor's SSN or ICN within 15 calendar days following receipt.

CLAIMS FILING DEADLINE

1.0. TIME LIMITATIONS ON FILING TRICARE CLAIMS

1.1. All TRICARE claims shall be stamped with an **I**nternal **C**ontrol **N**umber (ICN). The actual date of receipt shall be counted as day one. The ICN uniquely identifies each claim, includes the actual date received in the contractor's custody, and permits aging and counting of the claim for workload reporting purposes at specific system locations at any time during its processing. The contractor shall provide procedures to ensure the actual date of receipt is entered into the ICN and all required claims aging and inventory controls are applied for paperless claims.

1.2. All claims for benefits must be filed with the appropriate TRICARE contractor no later than one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. Professional services billed by the facility must be submitted within one year from the date of service.

EXAMPLE:

FOR SERVICE OR DISCHARGE	MUST BE RECEIVED BY THE CONTRACTOR
March 22, 2004	No later than March 22, 2005
December 31, 2004	No later than December 31, 2005

1.3. Any written request for benefits, whether or not on a claim form, shall be accepted for determining if the "claim" was filed on a timely basis. However, when other than an approved claim form is first submitted, the claimant shall be notified that only an approved TRICARE claim form is acceptable for processing a claim for benefits. The contractor shall inform the claimant in writing that in order to be considered for benefits, an approved TRICARE claim form and any additional information (if required) must be submitted and received by the contractor no later than one year from the date of service or date of discharge, or 90 calendar days from the date they were notified by the contractor, whichever is later. The claimant should submit claims on either the **CMS 1500 (08/05)**, the **CMS 1450 UB-04**, or the DD Form 2642 as appropriate.

2.0. EXCEPTIONS TO FILING DEADLINE

2.1. Retroactive Determinations

2.1.1. In order for an exception to be granted based on a retroactive determination, the retroactive determination must have been obtained/issued after the timely filing period elapsed. If a retroactive determination is obtained/issued within one year from the date of service/discharge, the one year timely filing period is still binding.

2.1.2. Only the Uniformed Services or the Department of Veterans Affairs may determine retroactive eligibility. For purposes of granting an exception, retroactive issuance of a Nonavailability Statement for inpatient mental health shall be treated as retroactive eligibility. Once a retroactive eligibility determination is made, an exception to the claims filing deadline shall be granted. A copy of the retroactive eligibility decision must be provided. In any case where a retroactive "preauthorization" determination is made to cover such services as the *Extended Care Health Option (ECHO)*, adjunctive dental care, surgical procedures requiring preauthorization, etc., the timely filing requirements shall be waived back to the effective date of the retroactive authorization. Claims which are past the filing deadline must, however, be filed not more than 180 days after the date of issue of the retroactive determination.

2.2. Administrative Error

2.2.1. If an administrative error is alleged, the contractor shall grant an exception to the claims filing deadline only if there is a basis for belief that the claimant had been prevented from timely filing due to misrepresentation, mistake or other accountable action of an officer or employee of TMA (including TRICARE Overseas) or a contractor, performing functions under TRICARE and acting within the scope of that individual's authority.

2.2.2. The necessary evidence shall include a statement from the claimant, regarding the nature and affect of the error, how he or she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed, as well as one of the following:

- A written report based on agency records (TMA or contractor) describing how the error caused failure to file within the usual time limit, or
- Copies of an agency letter or written notice reflecting the error.

NOTE: The statement of the claimant is not essential if the other evidence establishes that his or her failure to file within the usual time limit resulted from administrative error, and that he or she filed a claim within 90 calendar days after he or she was notified of the error. There must be a clear and direct relationship between the administrative error and the late filing of the claim. If the evidence is in the contractor's own records, the claim file shall be annotated to that effect.

2.3. Inability To Communicate And Mental Incompetency

2.3.1. For purposes of granting an exception to the claims filing deadline, mental incompetency includes the inability to communicate even if the result of a physical disability. A physician's statement, which includes dates, diagnosis(es) and treatment, attesting to the beneficiary's mental incompetency shall accompany each claim submitted. Review each statement for reasonable likelihood that mental incompetency prevented the person from timely filing.

2.3.2. If the failure to timely file was due to the beneficiary's mental incompetency and a legal guardian had not been appointed during the period of time in question, the contractor shall grant an exception to the claims filing deadline based on the required physician's statement. (See above.) If the charges were paid by someone else, i.e., spouse or parent,

statement should contain the date of the beneficiary's death and the signer's relationship to the beneficiary to enable the contractor to update the history file.

5.3. In the event that there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).

5.4. When there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, no next of kin, and no legal representative, the contractor shall arrange to pay the provider whether network or non-network for services rendered in accord with state law and corporate policy.

6.0. BENEFICIARY SIGNATURE ON FILE

Use of the signature on file procedure is the provider's indication that he or she agrees to the following requirements: Verification of the beneficiary's TRICARE eligibility at the time of admission or at the time care or services are provided. Incorporation of the language below, or comparable language acceptable to the TRICARE contracts, into the provider's permanent records.

6.1. Institutional Providers

"I request payment of authorized benefits to me or on my behalf for any services furnished me by **(Name of Provider)**, including physician services. I authorize any holder of medical or other information about me to release to **(Contractor's Name)** any information needed to determine these benefits or benefits for related services." Professional providers who submit claims on the basis of an institution's signature on file should include the name of the institutional provider that maintains the signature on file. The *CMS 1450 UB-04* instructions shall be followed for certifying signature on file except that the permanent hospital record containing a release statement will be recognized. Institutional includes all claims related to an institution.

6.2. Professional Providers

"I request that payment of authorized benefits be made either to me or on my behalf to Dr. _____, for any services furnished me by that physician. I authorize any holder of medical information about me to release to **(Contractor's Name)** any information needed to determine these benefits or the benefits payable for related services."

6.2.1. If a claim is submitted by a nonparticipating provider and payment will not be made to the patient, the provider must indicate the name, address, and relationship of the person to whom payment will be made. This will be the sponsor, other parent or a legal guardian for minor children or incompetent beneficiaries, except for claims involving abortion, venereal disease or substance/alcohol abuse.

6.2.2. Cooperate with the contractor postpayment audits by supplying copies of the requested signature(s) on file within 21 days of the date of the request and/or allow the contractor access to the signature files for purposes of verification. See [Chapter 1, Section 4, paragraph 4.1.](#) and [Chapter 12, Section 4, paragraph 3.0.](#) for audit requirements.

6.2.3. Correct any deficiencies found by the contractor audit within 60 days of notification of the deficiency of participation in the signature relaxation program will be terminated. Outpatient professional such as physician's office and suppliers such as Durable Medical Equipment (DME). Authorized individual providers have the option to retain on their own forms appropriate beneficiary release of information statements for each visit or obtain and retain in his or her files a one-time payment authorization applicable to any current and future treatment that the physician may furnish him or her. Claim forms must indicate that the signature is on file.

6.3. Institutional Claims

Outpatient hospital, professional inpatient and outpatient hospital services for release of information purposes, the provider must obtain the beneficiary or other authorized signature on a permanent hospital admission record for each separate inpatient admission. A professional provider submitting a claim related to an inpatient admission must indicate the name of the facility maintaining the signature on file. Claim forms must indicate that the signature is on file.

6.4. Professional Provider Claims

Outpatient professional such as physician's office and suppliers such as Durable Medical Equipment (DME). Authorized individual providers have the option to retain on their own forms appropriate beneficiary release of information statements for each visit or obtain and retain in his or her files a one-time payment authorization applicable to any current and future treatment that the physician may furnish him or her. Claim forms must indicate that the signature is on file.

6.5. Outpatient Ancillary Claims

Such as claims that are submitted from an independent laboratory where, ordinarily, no patient contact occurs. A provider submitting a claim for diagnostic tests or test interpretations, or other similar services, is not required to obtain the patient's signature. These providers must indicate on the claim form: "patient not present." For services when there is patient contact, such as services furnished in a medical facility which is visited by the beneficiary, the same procedure used for professional claims for outpatient services is required, except that the provider will indicate along with "signature on file" information, the name of the supplier or other entity rather than a physician maintaining the signature on file.

6.6. Verification Of Provider's Compliance With The Beneficiary Signature On File Requirement

The contractor shall verify beneficiary signature on file compliance using the postpayment audit requirement in [Chapter 1, Section 4, paragraph 4.1.](#), and the audit procedures in [Chapter 14, Section 4, paragraph 3.0.](#)

7.0. UNACCEPTABLE SIGNATURES

A provider or an employee of an institution providing care to the patient may not sign the claim form on behalf of the beneficiary under any circumstances. Nor can an employee of a contractor execute a claim on behalf of a beneficiary (unless such employee is the beneficiary's parent, legal guardian, or spouse). Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and/or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness. If the beneficiary is unable to sign due to an incapacitating condition/illness, the provider can annotate in the Signature Box on the TRICARE claim form "Unable to sign." A letter from the provider shall be attached to the claim form describing the physical and or mental incapacitating illness. For those illnesses which are temporary, the letter needs to specify the inclusive dates of the illness.

8.0. BENEFICIARY SIGNATURE WAIVER

8.1. Administrative Tolerance - Certain Ancillary Services

Claims for inpatient anesthesia, laboratory and other diagnostic services in the amount of \$50 or less, provided by physician specialists in anesthesiology, radiology, pathology, neurology and cardiology should not be returned for beneficiary signature unless required by state law or contractor corporate policy. Claims submitted by an institution when the claim is for those specific ancillary services cited above, should be included in this tolerance if the services were performed in an institution other than the institution in which the beneficiary is receiving inpatient care.

8.2. Beneficiary (Sponsor, Guardian Or Parent Moved) Unable To Locate

Requirements for a beneficiary's (sponsor, guardian or parent) signature should be waived in the following situations for claims received from non-network participating providers. The contractor should grant a waiver after the procedures described below have proven unsuccessful. If unable to obtain a signature because the beneficiary has moved and left no forwarding address, the contractor shall attempt to obtain the address by telephone or from internal files, or DEERS. If a new address is obtained, the original claim should be returned to the beneficiary or sponsor with a request for signature. If the claim was submitted by a provider, a **copy**, with the diagnosis and any sensitive information deleted, shall be sent to the beneficiary or sponsor. If the signature is not obtained because the new address is still not valid and the patient cannot otherwise be located, the contractor should grant a signature waiver for a participating provider. Nonparticipating provider claims must be denied. However, if the address is valid, and the contractor knows, through the claim development process, that the beneficiary or sponsor does not wish to file a claim, the

claim(s) must be denied whether or not the provider participates. If the contractor obtains a new address, this address cannot be released to the provider.

9.0. NETWORK PROVIDER SIGNATURE

Signature requirements for network providers are dependent upon the provisions of the agreement and administrative procedures established between the providers and the contractor.

10.0. NON-NETWORK PROVIDER SIGNATURE

The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. *The provider's signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim.* If a non-network participating claim does not contain an acceptable signature, return the claim. The provider's signature is also required to certify services rendered when a provider completes a nonparticipating claim for the beneficiary. If the provider does not sign, the contractor may contact the provider by telephone to verify the delivery of services or return the claim for signature. A claimant may also attach an itemized bill on the letterhead/billhead of the provider verifying delivery of services.

10.1. Facsimile Or Representative Signature Authorization

In lieu of a provider's actual signature on a TRICARE claim, a facsimile signature or signature of a representative should be accepted if the contractor has on file a notarized authorization from the provider for use of a facsimile signature (Chapter 8, Addendum A, Figure 8-A-2) or a notarized authorization or power of attorney for another person to sign on his or her behalf (Chapter 8, Addendum A, Figure 8-A-3). The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated. The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.

10.2. Verification Of Provider Signature Authorization

In the absence of any indication to the contrary, contractors should assume the proper authorization is on file, validating through file checks, those claims containing facsimile and representatives' signatures which are included in their quality control audit, and program integrity samples. The contractor should remind providers of the requirement for current signature authorizations through at least annual notice in routine bulletins or newsletters and at other appropriate times when contacts are made. The contractor may return a claim with a request for the signature authorization when it is found that there is no authorization on file or it is out-of-date:

- Send a request to the provider advising of the need for authorization and;

- Set a utilization flag on the provider's file to stop further payment to the provider when the proper signature is not on the claim, pending receipt of the authorization.
- Advise the provider that if the authorization is not received, it will be necessary to deny the claim or to process it as a nonparticipating claim, depending on the information available to make a payment determination.
- Schedule a contractor representative visit to resolve any problem which may develop in the unlikely event a provider chooses not to cooperate.

10.3. Certification Of Source Of Care

Source of care certification is used to help determine the correct payee on the participating UB-92/UB-04 and the CMS 1500. *The CMS 1450 UB-04 has eliminated the provider's signature block FL from the form. As a work around, the NUBC has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim. Submission of the UB-04 claim form by an institution or provider certifies the institution or provider is complying with all the TRICARE certifications on the reverse of the claim. Provider signature on file requirements apply to the claims if not signed.* If signed by the provider and the certification is unaltered, issue payment to that provider. If signed with alteration of the certification, issue payment to the beneficiary (parent/legal guardian of minor or incompetent). If unsigned and an itemized billing on the provider's letterhead is not attached, return the claim.

NOTE: For procedures in case of any irregularities, refer to [Chapter 14](#), Program Integrity.

3.6. Cost-shares and deductibles applicable to TRICARE will also apply under this Demonstration. For TRICARE Prime enrollees, including those enrolled in USFHP, applicable co-pays will apply, if any.

3.7. The Assistant Secretary of Defense (Health Affairs) approved this DoD demonstration commencing on the effective date of participation, which is the date 30 days after publication of the Notice in the Federal Register, with those enrolled having periodic examinations during a three-year follow-up period.

4.0. APPLICABILITY

4.1. The provisions of this demonstration are limited to those TRICARE-eligible beneficiaries and active duty service members whose fetuses have been diagnosed with myelomeningocele at 16 to 25 weeks' gestation and who are at the age of 18 years or older (on the date of enrollment). The demonstration does not apply to those TRICARE-eligible beneficiaries enrolled in the Continued Health Care Benefit Program (CHCBP), or the military retirees' Federal Employees Health Benefits Program (FEHBP).

4.2. Inquiries and claims related to the Demonstration's *prenatal protocol*, excluding claims for *the post-natal protocol*, shall be submitted to the *South Region* referencing the Department of Defense In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration. *All inquiries and claims related to the Demonstration's post-natal protocol shall be submitted to the appropriate regional MCS contractor, as these services are covered under the Basic Program.* The DoD has no authority regarding the NICHD protocol eligibility for the sponsored study. Therefore, if a patient does not meet the criteria for enrollment, appeal rights do not apply.

5.0. GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS

The regional MCS contractor shall verify the TRICARE eligibility of the patient on the Defense Enrollment Eligibility System (DEERS). Patient selection will be made by the Biostatistics Center (BCC) at George Washington University in Rockville, Maryland in accordance with the protocol. Those patients remaining eligible and interested will be assigned by the BCC to one of the three participating MOMS centers. The contractor will not be involved in medical necessity or clinical review of the Demonstration claims. Claims for approved care under the Demonstration shall be submitted to the *South Region* for adjudication.

6.0. ASD(HA) RESPONSIBILITIES

ASD(HA) is the designated Executive Agent for the Demonstration project. They shall designate a project officer in the Office of the DASD (Clinical Services) for the Demonstration. The project officer shall provide clinical oversight and resolve any clinical issue among DoD, NICHD and MCTDP.

7.0. THE BIOSTATISTICS CENTER (BCC)

For the myelomeningocele clinical trial, the BCC will serve as a referral center for patients and coordinate the outcome evaluations, including both the review of the MRI, and ultrasounds, as well as the infant follow-up examinations. The BCC may be contacted at:

Dr. Catherine Shaer, Program Manager
Management of Myelomeningocele Study (MOMS)
The Biostatistics Center, The George Washington University
6110 Executive Boulevard, Suite 750
Rockville, MD 20852
Call toll-free: 1-866-ASK-MOMS (1-866-275-6667)
Fax toll-free: 1-866-458-4621
<http://www.spinabifidamoms.com>

8.0. PARTICIPATING MOMS CENTERS

8.1. Participating MOMS centers will be responsible for obtaining information regarding possible third-party liability and other health insurance (OHI) coverage of the TRICARE beneficiary. The MOMS centers shall collect from third party or the OHI and bill any remaining balance of the total amount to the appropriate regional contractor within 30 days of the receipt of the payment from the OHI. The MOMS centers shall ensure proper entry regarding the OHI on the *CMS 1450 UB-04* claim form before submitting the claim form to the contractor.

8.2. In the event that the MOMS centers are unable to collect from a third party or the OHI for health care services that would be covered under the third party liability or by the OHI if provided by a private provider, no bill shall be presented by the MOMS centers to the DoD contractor. The MOMS centers shall determine patient acceptance for participation in the Demonstration in accordance with the protocol outlined in [Figure 20-3-1](#).

8.3. Participating MOMS centers shall request reimbursement for inpatient services provided under the Demonstration completing a *CMS 1450 UB-04* and submitting the form to the appropriate regional contractor. Reimbursement will be based on billed charges, which will cover all professional and institutional services. The MOMS centers shall be responsible for collecting the beneficiary cost-shares from TRICARE patients. The participating MOMS centers shall submit all charges on the basis of fully itemized bills. Each service and supply shall be individually identified and submitted on the appropriate claim forms. In cases where care of a TRICARE-eligible patient is terminated under the clinical trial, the MOMS centers shall submit the claims to the contractor within 30 days of such termination.

8.4. The MOMS centers shall establish a POC to respond to inquires related to participation in the Demonstration and for coordination with the regional contractors. Unless otherwise agreed to between NICHD and DoD/TMA, the coordination support by the MOMS centers shall be provided for up to 12 months after termination of the demonstration.