

## Chapter 8

## Addendum A

### Figures

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Due to the size and nature of the first figure, [Figure 8.A-1](#) can be found on page 2.

**TRICARE Operations Manual 6010.56-M, February 1, 2008**

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Figures

**FIGURE 8.A-1 DEPARTMENT OF DEFENSE (DoD) DOCUMENT (DD) FORM 2642**

<p><b>TRICARE DoD/CHAMPUS MEDICAL CLAIM PATIENT'S REQUEST FOR MEDICAL PAYMENT</b></p>	<p>OMB NO. 0720-0006 OMB approval expires Aug 31, 2009</p>
<p>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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0720-0005). 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.</p> <p><b>PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.</b></p>	
<p><b>PRIVACY ACT STATEMENT</b></p>	
<p><b>AUTHORITY:</b> 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.  <b>PRINCIPAL PURPOSE(S):</b> 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.  <b>ROUTINE USE(S):</b> Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.  <b>DISCLOSURE:</b> Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.</p>	
<p><b>IMPORTANT - READ CAREFULLY</b></p>	
<p>Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.</p>	
<p><b>INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT</b></p>	
<p><b>NONAVAILABILITY STATEMENT REQUIREMENTS:</b> If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a <u>bona fide emergency</u>. Without a necessary NAS your claim will be denied.</p> <p align="center">*****</p> <p><b>ITEMIZED BILL:</b> 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:</p> <ol style="list-style-type: none"> <li>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;</li> <li>2. Date of each service;</li> <li>3. Place of each service;</li> <li>4. Description of each surgical or medical service or supply furnished;</li> <li>5. Charge for each service;</li> <li>6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.</li> </ol> <p><b>DRUGS:</b> Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available; the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.</p> <p align="center">*****</p> <p><b>TIMELY FILING REQUIREMENTS:</b> All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice -- whichever date is later.</p> <p align="center">*****</p> <p><b>WHERE TO OBTAIN ADDITIONAL FORMS:</b> You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity, 16401 E. Centretech Pkwy., Aurora, CO 80011-9066.</p> <p align="center">*** REMINDER ***</p> <p>Before submitting your claim to the claims processor be sure that you have:</p> <ol style="list-style-type: none"> <li>1. <b>Completed all 12 blocks on the form.</b> If not signed, the claim will be returned.</li> <li>2. Verified that the sponsor's SSN is correct.</li> <li>3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.</li> <li>4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.</li> <li>5. Obtained a Nonavailability Statement if required (see information above).</li> <li>6. Attached DD Form 2527, "Statement of Personal Injury -Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side.</li> <li>7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments.</li> <li>8. Made a copy of this claim and attachments for your records.</li> </ol>	



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**FIGURE 8.A-2 PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION**

State of \_\_\_\_\_ )  
\_\_\_\_\_ )ss  
County of \_\_\_\_\_ )

\_\_\_\_\_ being first duly sworn, deposes and says: I hereby authorize the **(Contractor for TRICARE in the State)** of to accept my facsimile or stamp signature shown below.

**(Facsimile, stamp or computer generated signature as it will appear on the claim form.)**

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

Signature

Subscribed and sworn to before me this \_\_\_\_\_ day of 20\_\_\_\_.

\_\_\_\_\_  
Notary Public in and for  
\_\_\_\_\_ County, State of \_\_\_\_\_

(SEAL)

My Commission expires \_\_\_\_\_

**TRICARE Operations Manual 6010.56-M, February 1, 2008**

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**FIGURE 8.A-3 PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION**

State of \_\_\_\_\_ )  
\_\_\_\_\_ )ss  
County of \_\_\_\_\_ )

Know all persons by these presents:

That I, \_\_\_\_\_ have made, constituted and appointed and by these presents do make constitute and appoint \_\_\_\_\_ my true and lawful attorney-in-fact for me and in my name place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claims forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_.

Signature

Subscribed and sworn to before me this \_\_\_\_\_ day of 20\_\_.

\_\_\_\_\_  
Notary Public in and for  
\_\_\_\_\_ County, State of \_\_\_\_\_

(SEAL)

My Commission expires \_\_\_\_\_

**FIGURE 8.A-4 ABORTION DENIAL NOTICE TO THE BENEFICIARY AND PARTICIPATING PROVIDER**

Date: \_\_\_\_\_

Sponsor's Name: \_\_\_\_\_

Beneficiary's Name: \_\_\_\_\_

Type of Service(s): \_\_\_\_\_

Date of Service(s): \_\_\_\_\_

Last four digits of

Sponsor's SSN: \_\_\_\_\_

PERSONAL

\_\_\_\_\_  
To: \_\_\_\_\_

Dear \_\_\_\_\_:

TRICARE coverage of abortion services is specifically limited by federal statute. As implemented by the Department of Defense, TRICARE coverage of abortion services is limited to when:

- The life of the mother is at risk if the fetus is carried to term -- based upon certification from the attending physician that the patient suffers/suffered a condition that endangered her life if the fetus were carried to term; and
- The pregnancy is the result of an act of rape or incest -- as documented in the patient's medical record (effective January 2, 2013).

This means TRICARE won't cost-share on abortions performed for reasons other than those listed above. Since initial review of your claim(s) gave no indication that this abortion met the conditions for coverage, TRICARE denied the claim.

If you believe you do qualify under one of the exceptions, you may request a Reconsideration of the denial decision by submitting a written Reconsideration request to this office within 90 days of the date of this notice. Your request must include a copy of this notice, a statement outlining why you disagree with the decision, and any additional information/documentation from your physician which will support your position.

If you have any questions concerning the TRICARE abortion policy, please contact (Contractor Name and Address).

Sincerely,

- END -